EDUCATION OF "THE OTHER HALF" OF THE HEALING EQUATION – (THE CITIZEN PATIENTS)

Comments to the White House Commission on Complementary and Alternative Medicine

February 23, 2001

by

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The Key to a Cost-effective U.S. Health System: Educated Patients

Rationale

Perhaps the most significant difference between contemporary, mainstream U.S. medical practice and the "CAM" or "whole person healing" model is the vastly increased role of the patient in the Healer-Patient interaction. It is acknowledged as an axiom of much CAM that the Doctor ⇄ Patient is an interactive system. The patient is actively involved in the healing.

It is the principal thesis of the comment that the Commission emphasis on education should not neglect the other half of the interaction in all CAM healing - the patient or citizen – in the target population to receive education.

Among the significant dicta of Hippocrates is not only: "First do no harm", but "It is more important to know the person who has the disease than the disease the person has..." In today's version Hippocrates might say, "It is as important to educate the person who has the disease, as the healer who will help the person."

Much, if not most, of the attention in the area of education, in this Commission, has focused on the education of the healer (whether physician or alternative provider). We believe it is at least equally, important to be concerned about the **education of the "patient"**.

Indeed it is quite safe to claim that the entire rise of the field of integrative medicine has been caused by the education of the putative patient. CAM's history is a shining example of the power and success of mass education in the very best sense, by the use of "informed sources". These have included word of mouth, small community networking (e.g. via church groups), and the TV and print media. The latter due to their access to huge numbers of citizens has made the CAM movement. The tidal wave of interest and use of "alternatives" is in no small measure correlated with the repeated national TV appearances of CAM leaders such as Andrew Weil, Deepak Chopra, Larry Dossey, etc. Yet the Web, and all these media have no quality control mechanisms. Nor are they in any sense systematic. Clearly there is a place for systematic, reliable education via the formal channels of college and school.

Education of the Citizen in Health as in Science

In 1982 the House of Representatives Committee on Science, going against both the Administration and the Academic establishment, tackled the matter of the much-neglected "Science Education" both of the professionals and of the public. In the Senate, the Kennedy – Hatfield resolution urged a focus on the technological and scientific literacy of the general population. In the event, the NSF Science **Education** budget was expanded continuously, and has reached about $700 million/year. It is now supported by all constituencies. Precedents clearly exist for what is being proposed herein for formal education of the masses. Moreover the pay off in better health at lower cost will be very large and direct within a decade.

Proposal

It is our proposal that this White House Commission strongly recommend the initiation of a vigorous Federal program to include, as a major component, the education of the "citizen-patient". Nothing in our view would be more cost-effective or timely to develop an American cost-effective healthcare system where the citizens' taking of responsibility based on sound education, would make the difference.

The potential scope of such an educational program is vast. Initially one could start with a focus on the general education courses offered in every college – several million citizens per year. The great advantage of using the formal educational processes is that we bring some quality control (but no dogmatic position) into the material presented. This number will of course be expanded by the various (Web based) continuing education efforts of the many universities and community colleges that will get involved. Partnering with the large CAM community's efforts and private sector educational efforts should be encouraged wherever appropriate. Targeting underserved and minority populations is especially important because the payback may be greatest there.

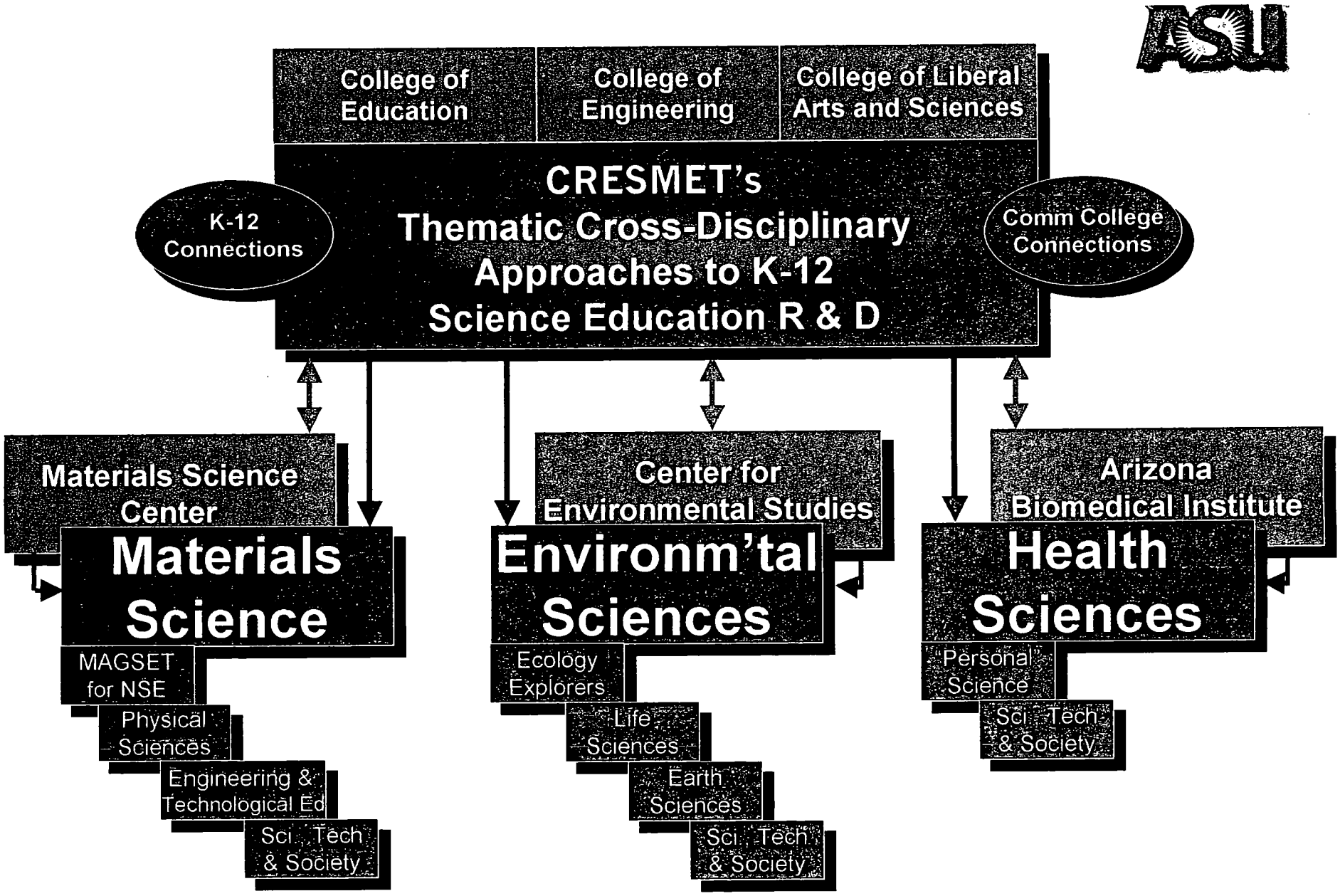
It is acknowledged by all sides that the most significant correlate of good health is level of education. Of course part of that is due to socio-economic factors. But part of it is strictly due to more knowledge about health maintenance and use of CAM procedures.

That is what this selective education program must be aimed at. It would also certainly offer one of the bright spots in the economic future of the U.S. health care system. Moreover its cost would be a fraction of the research on new drug for just one disease.

Administration

N.I.H. is a research agency. This health education program would not fit in at all. Instead it is proposed that the Commission recommend a Citizen-Patient Health education initiative to be administered as a joint program of the U.S. Public Health Service and the NSF (or Department of Education).

The level of funding can parallel the science education funding efforts in Federal agencies escalating from a $50 million/year to $500 million/year in a decade.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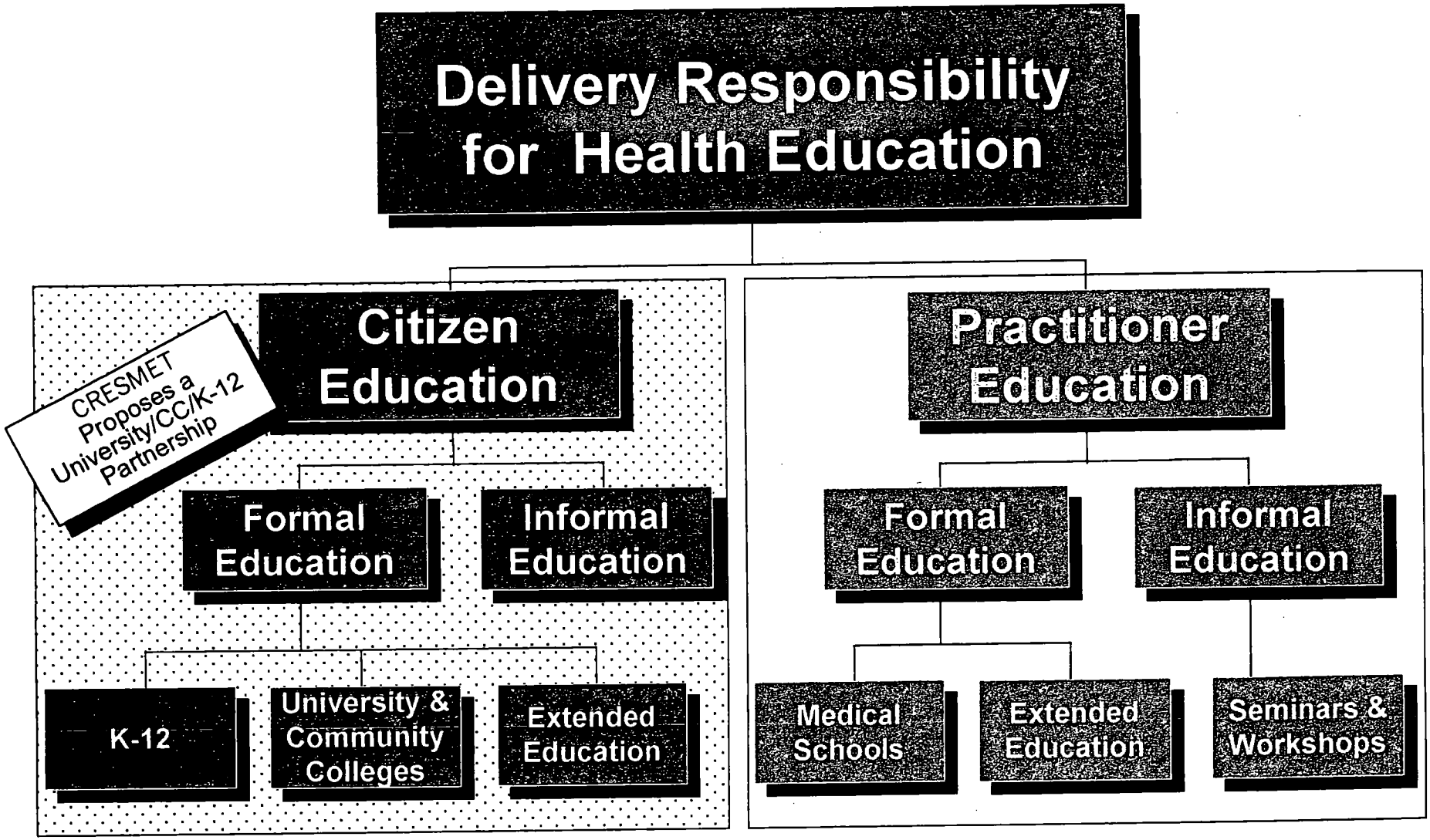
"The Strongest Correlate of Good Health is Education"



Also sent to Dean, Charlotte, Tom, + Ming

Close

From: Axelrod, Corinne (NCCAM)

To: 'jsgordon@mindspring.com'; 'bresler@aol.com'; 'wjonas@usuhs.mil'; 'linnealarson@mac.com'

Cc:

Subject: WHCCAMP - Wellness

Sent: 2/15/01 2:51 PM **Importance:** Normal

Dear Commissioners Jim Gordon, David Bresler, Wayne Jonas, and Linnea Larson,

Thanks to each of you for volunteering to work on the Wellness Planning group. The Commission session on Wellness will be on Friday, March 27th, following the March 26th session on Information Development and Dissimination.

In developing a draft agenda for us to work with, I have tried to differentiate between the vast array of wellness-related issues (in a sense, all parts of our lives are related in some way to wellness) and what the Commission should focus on in terms of CAM. One approach could be to focus on the role and opportunities for CAM in developing and maintaining wellness and health, and include topics such as: CAM in Nutrition and Environmental Health; CAM and Wellness in Federal Programs; Corporate, Private, and International Approaches to Wellness that include CAM; and CAM and Wellness Education. However, for some of these topics, (e.g. the environment), the issues impacting on wellness are far broader than CAM and may be difficult to address. For others, (e.g. corporate approaches), CAM can easily get reduced to piecemeal activities such as a company offering yoga classes for their employees.

While all of these are important and contribute to the topic, we would like to design a meeting that views Wellness as more than health, more than just exercise and eating right, and captures more of a world vision of how CAM can impact on people's well-being and how that can be promoted as a component of the concept of "Wellness".

So before I proceed any further, I would like to get your thoughts on how this meeting should be structured to make the best use of everyone's time, and lead the Commission to the formulation of substantive recommendations. Unfortunately, we don't have a lot of time to plan this meeting, so I'm hoping that we can have some email discussion that will give me some guidance in developing a draft agenda and then a conference call after the Education and Training meeting to review it.

Thanks again, and I'm looking forward to hearing your thoughts.

Corinne Axelrod, M.P.H.
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"I recommend Peggy Huddleston's book to all who require surgery and want to recover faster."
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Author, *8 Weeks to Optimum Health*
Director, Program in Integrative Medicine
University of Arizona

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From the foreword by
Christiane Northrup, M.D.
Author, *Women's Bodies, Women's Wisdom*

"Best book I have ever seen showing how to prepare for surgery — physically, emotionally and spiritually."
Joan Borysenko, Ph.D.
Author, *Minding the Body, Mending the Mind*
Co-founder
Mind/Body Clinic
Beth Israel Deaconess Medical Center

"This book is a wise guide for anyone having surgery."
Larry Dossey, M.D.
Author, *Healing Words*

February 23, 2001

Dear White House Commission on Complementary and Alternative Medicine Policy,

I am a psychotherapist and author of the book *Prepare for Surgery, Heal Faster: A Guide of Mind-Body Techniques.* I've developed a 5-step protocol that shows people how to use mind-body techniques to:

- Feel calmer before surgery
- Use 23-50% less pain medication after surgery
- Heal faster

The program is based on a growing body of research. A meta-analysis of 191 studies with 8,600 patients documents that patients who prepared for surgery had less bleeding, fewer complications, used less pain medication and a shorter length of stay.

Principal Investigator of Research Studies at Harvard Teaching Hospitals
Currently I am the principal investigator of three randomized, controlled, research studies at three Harvard Medical School teaching hospitals documenting the efficacy of my program with patients having total knee-joint replacement, abdominal hysterectomy and open-heart surgery.

With Benjamin E. Bierbaum, Chief of Orthopedic Surgery at the New England Baptist Hospital, a Tufts and Harvard Medical School teaching hospital, I've recently completed a randomized, controlled study with 44 patients having total-knee joint replacement that has been submitted for publication in a peer-reviewed journal. Controlling for the placebo effect, it's findings documented that patients using my pre-surgical method were significantly less anxious the day before surgery and left the hospital one-and-a-third days sooner to go to rehabilitation.

It resulted in a savings of $3,000 a patient since patients left the hospital within the three days paid for by insurance. This is significant savings at a time that 1/3 of America's hospitals are losing money. My abstract of the research is enclosed.

Used by Leading Hospitals Across the Country
Since 1996 my program has been used by more than 200,000 people. It has been instituted by major hospitals across the country including: NYU Medical Center in New York, several Kaiser Permanente hospitals (the countries largest HMO), UCSF Cancer Resource Center in California, Saint Barnabas Medical Center, the largest chain of 14 hospitals in New Jersey, Imperial Point Medical Center in Florida and Hartford Hospital in Connecticut.

(over)

Five-Steps to Prepare for Surgery

My method consists of the following:

Step 1: Use a Relaxation/Healing audio-tape

Feeling peaceful strengthens the immune system and creates the complex bio-chemistry of healing.

Step 2: Use Visualization to Turn Worries into Healing Images

Step 3: Create a Support Group

Ask friends & family to wrap you in a blanket of loving thoughts 1/2 hour before surgery. People report feeling more loved than they have ever felt.

Step 4: Use "Healing Statements"

Words spoken during surgery reduce the use of pain medication 23-50%.

Step 5: Meet the Anesthesia Staff to Request Use of "Healing Statements"

Pilot Task Force from Medicare and Armed Forces

A pilot task force from Medicare and the Armed Forces could document the efficacy of my program. My intervention is modest in price: whole cost is $9 for the book and $6 for the Relaxation/Healing audio-tape which will result in an increase in patient satisfaction and major cost savings for the government. My program can be offered with or without a one-hour workshop given by a nurse or social worker trained in my method.

Recommended Public Policy

If Medicare and the Armed Forces offered my program as a benefit to patients, it would empower patients and their families to use medically proven relaxation and visualization techniques to feel profoundly peaceful before surgery and speed their recovery afterwards. This public policy would offer patients tangible tools to become active participants in their health care. It would greatly reduce people's anguish and fear before surgery and provide tools to connect with a deep inner peace that can be life enhancing.

Increase Funds for Research

Since more than 35 million Americans have surgery each year, I would ask the Commission to recommend more funding of research studies in this area.

I applaud your efforts of this Commission.

Sincerely,

Peggy Huddleston

Peggy Huddleston
Project Director and Board Member
Center for Psychology and Social Change
affiliate of the Department of Psychiatry
The Cambridge Hospital, Harvard Medical School

OR Manager

The monthly publication for OR decision makers

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Kaiser hospital offers mind-body workshop for surgical patients

Gynecologic oncology patients leaving the hospital in 3 or 4 days after a total abdominal hysterectomy—a day or two less than usual. A patient who has had a craniotomy for a meningioma awakening in the recovery room asking for strawberries and wanting to go home.

These are effects anesthesiologist Jean Henney, MD, says she has seen since instituting psychological preparation for surgery.

Henney has championed a program at the Kaiser Foundation Hospital in Santa Clara, Calif, to offer workshops, tapes, and affirmations to patients who want to prepare psychologically for their procedures. About 200 patients have participated since May.

The hospital is using a program developed by Peggy Huddleston. The one-hour workshop is given by nurses trained and certified by Huddleston, a psychotherapist and researcher. She is conducting research on outcomes of the program with several Harvard teaching hospitals.

Tools for healing

A core group of nurses and other professionals have taken the two-day training to conduct the program, which has five steps:

1. Relax to feel peaceful, using relaxation tapes.
2. Visualize your healing through healing imagery.
3. Organize a support group of family and friends.
4. Use healing statements during surgery.
5. Meet your anesthesiologist to establish a supportive relationship.

The program is offered through the anesthesia preoperative clinic. Patients are informed about it in the surgical clinics and during their preoperative phone call.

Interested patients can sign up for a workshop, which is given twice a day for $25 and includes Huddleston's book and audiotape.

Patients use the book and tapes at home to continue their preparation. On the day of surgery, those who have requested the service are noted on the surgery schedule. Patients bring their tape and tape player so they can listen in the preoperative area. They may be paired with a trained volunteer who can reinforce their healing statements. Nurses can also reinforce the statements. Patients request that their healing statements be repeated in the OR.

"All of the anesthesia personnel are familiar with the program and willing to say the healing statements," says Dr Henney. "Many do it anyway."

Patients are encouraged to listen to their tapes in the recovery unit and during recuperation at home.

"Results have been overwhelming," says Virginia Field, RN, MBA, CNOR, manager of perioperative services. Since May, the hospital has received more letters than usual from patients, all positive.

Along with Dr Henney, Field and Shelley Mckee, RNC, MN, CNOR, the perioperative educator, are developing a model to collect data on outcomes.

Takes a champion

What does it take to get a program off the ground?

"A champion," says Field. Having Dr Henney lead the effort was important in securing support of other physicians. She added that the medical director of the OR and the anesthesia director support innovation.

"You need a critical mass of interest within the organization," Dr Henney comments. She has promoted preoperative preparation for 7 or 8 years but is just starting to see interest take off.

The hospital funded the training for the staff because it sees the potential benefits and is about to approve funding for running the workshops full time.

"I think there is the potential that this will be cost shifting," Dr Henney says. Eventually, she thinks preoperative psychological preparation may be funded from what is saved by patients' more rapid, smoother recoveries. ❖

American Holistic Medical Association

Book Review

by David Edelberg, M.D.

Chairman and Medical Director
American Holistic Centers

Prepare for Surgery, Heal Faster

If every managed care medical director simply mandated that a copy of ***Prepare for Surgery, Heal Faster*** (book with accompanying audiotape) by psychotherapist Peggy Huddleston be given to all patients undergoing elective surgical procedures, the cost savings could easily add another million to his annual salary with plenty to spare for the HMO's executive team.

Faced with the prospect of high tech invasion of our bodies, most of us are quite sensibly terrified and confused. These two states of mind are not (holistically speaking) associated with wellness and most certainly lay the groundwork for post-operative complications, delayed wound healing, and unnecessarily long hospital stays.

Huddleston quotes a number of studies in which relaxation techniques, guided in imagery, and meditation significantly reduced lengths of stay. Both the book and the tape have very effective programs of reassured calm and healing images. To humanize the whole process, the author suggests interviewing both the surgeon and the anesthesiologist before-hand, with the sensible request that some healing words be spoken and some soft music be played through a Walkman worn throughout the procedure.

To order *Prepare for Surgery, Heal Faster*
(617) 497-9431 in Cambridge, Mass.
(800) 726-4173

Save 35% ordering at www.healfaster.com

Additional Testimony Points

Diane M. Miller JD
Executive Director of National Health Freedom Coalition:
Providing legal information and resources for decision-makers involved in reform for complementary and alternative health care.
Defense Counsel for complementary and alternative practitioners and healers
Drafter and Lobbyist for MN Model

Additional Points to Keep in Mind Regarding Credentialing and Government Regulation in addition to testimony already before you:

1. **Problem: Unlicensed healers are illegal. They can be charged criminally**. This means that consumers don't get access to these healers unless the healers are willing to work in a vulnerable legal situation.

   There are 1000s of unlicensed healers, permeated throughout the culture, many in solo practice without affiliation to national groups, with a broad array of backgrounds and talents, many of whom use a combination of skills to assist consumers.

2. **Licensed practitioner and healers can lose there license. They can be disciplined by their Boards**. This means that consumers don't get access to these types of healers unless the practitioners are willing to work in a vulnerable legal situation.

   There are 1000s of licensed healers across all professions utilizing a broad range of healing arts, specific to their own personal interests, having gotten their information from many sources, and utilizing it to assist patients.

3. **Educational credentials or degrees are not the same as government delegated titles and regulation**. There are 1000 of groups that promote educational credentials and accreditation of schools and degrees. Many of these groups also support the practice of their profession by non-degreed individuals. Example, Northwestern School of Homeopathy.

   Many national groups are adopting policies of non-exclusion but continuing on the path of advancing various kinds of private credentials and excellence. Many natural health disciplines acknowledge some of their greatest teachers do not have the credentials and degrees and do not want government to exclude them.

   If regulation is necessary for harmful practices, then the use of least restrictive regulation is important to avoid using scope of practice laws that promote turf battles. Jurisdiction statutes rather than scope of practice statutes work better to avoid this problem

4. **Consumer expectations are based on the location and culture in which they find themselves**. That is the beauty of culture. Pluralism is an important component of a strong society. Free expression of rituals and traditions make for a rich culture. Federal homogeneity should be reserved only for those situations that pose an imminent risk of harm to the country as a whole, to a community or to an individual. Uniformity around safety should always be balanced with free expression of a culture.

Addition Recommendations (in addition to the attached document of Finding and Recommendations of the National Health Freedom Coalition):

1. Reform laws so that unlicensed healers and practitioners are not charged criminally for practicing their trade or art. Charge only when a practitioner has broken other regular criminal laws already in place. Consumer have the right to access all healers and all healers should have an legal avenue of accessibility to consumers.

2. Reform laws so that licensed practitioners and healers always have legal avenues in which they can practice healing practices outside of the prevailing standard of care. Consumers have the right to access all licensed practitioners practicing outside of their prevailing and accepted standard of care and all practitioners should have a legal avenue of accessibility to consumers.

3. Adopt public policy that promotes:

   a. education and innovation without leaving individuals or groups that do not participate in that education in legal jeopardy and inaccessible to consumers.
   b. the use of all healing behaviors across all occupational disciplines whenever possible. When that is not possible due to imminent risk of harm then adopt public policy that promotes extensive collaborative models of delivery and promote cooperation between groups.
   c. adopt public policy in health that demands a consumer informed environment in all health related circumstances. The Client Bill of Rights in MN is an example of a great tool to disseminate information to consumers as well as providing a way for written information to make its way between a host of other practitioners.

4. United States citizens should always allocate the burden of proof to the government for any restriction on their choices of healing treatments or practitioners. The legal standard of imminent risk of harm to consumers is a proper standard for government oversight.

5. For review of National Health Freedom Coalition Findings and Recommendations please see attached document.

FINDINGS AND RECOMMENDATIONS FOR COMPLEMENTARY AND ALTERNATIVE HEALTH CARE REGULATION

Produced by

National Health Freedom Coalition

The National Health Freedom Coalition finds that:

1. Every individual has the basic right of self-determination and the right to make their own personal choices in the process of healing. Each individual person is ultimately responsible for securing their own health and well being and making decisions to that end.

2. In order to have the right of self-determination, in the fullest sense of the word, every person has a constitutional right of access to any healing or health care practitioner, treatment, or information source they desire. This right remains, whether or not treatment options are generally accepted, well known, recognized, or researched, and regardless of a practitioner's education, training, and experience.

3. There is a broad range of types of health care practitioners and healing modalities and treatments available, be they conventional or nonnconventional, holistic, integrative, natural, or culturally specific, and many of these have provided people with profound healing effects. The individual has the ultimate responsibility for assessing whether a particular treatment or practitioner has been or is likely to be beneficial to them in their healing process.

4. Studies indicate that consumers are placing increased reliance on nonconventional healthcare providers and healing modalities to avoid the excessive cost of conventional medical services and to obtain more holistic consideration of their needs.

5. The role of the government in healthcare is to protect citizens from harm, and at the same time to protect citizen rights to individual choice and autonomy.

6. The basic right of self-determination dictates that regulations are not to be imposed that impact consumer individual rights unless they are clearly required for the safety and well being of citizens. If regulations are imposed, the following criteria should be used: 1) necessity to protect the safety and well being of citizens, and 2) use of the least restrictive means of regulation possible.

7. The least-restrictive means of regulation, balancing the role of the government to protect individuals from harm with the role of the government to protect individual autonomy and choice, should be founded on principles of a consumer informed environment and clear avenues of consumer recourse for complaints.

8. Consumers benefit from, and deserve to have, truthful information in order to make informed choices regarding their healthcare. For example, a consumer benefits when a practitioner is required, before treatment begins, to give disclosure to the consumer regarding the method of healthcare they provide and their training and experience in the health care they practice.

9. Consumers benefit from having accessible places to direct their complaints and deserve to be supported in their expectation of receiving ethical treatment and truthful information. For example, if a person has been harmed or put in the position of imminent risk of direct harm by a modality or a practitioner relationship, the government should have in place a mechanism for consumer complaint and clear grounds for disciplinary actions to correct the situation.

Re: State Occupational Regulation

10. The use of state licensure, registration, and certification to regulate health care occupations is not the least restrictive means of regulation and can negatively impact consumer options when used as the sole means of regulation. In fact, licensure is the most restrictive type of regulation, utilizing the broadest sweep of police power possible for occupations. Licensure laws typically describe an area of practice, demand particular types of education and training and use of exclusive titles for that practice, demand that the practitioner stay within the prevailing standard of care of the education and training mandated by the government for that practice, and then exclude all other persons from practicing in that area of healing.

11. Consumers are disempowered by states that only use the most restrictive means of regulation and do not provide an additional form of regulation that protects consumer options. Health-care regulations that are exclusive, that bestow ultimate power on particular types of professional and delivery systems to the exclusion of others, and that limit available healing practitioners and treatments through enforcement of exclusive and restrictive occupational laws, decrease consumer options in health care and infringe on the individual's basic right of self-determination to make choices.

12. Consumers are empowered by states that use additional least-restrictive means regulations that ensure all practitioners the right to practice and the right to use the full range of treatment methods. These states maximize consumer choice and protect the right of self-determination of the individual to make informed decisions about their health and acknowledge and respect consumer needs for meaningful information and reasonable practitioner/client relationship expectations.

13. There are recognized problems that occur when a state attempts to use exclusive and restrictive occupational regulation for nonconventional, holistic, integrative, natural or culturally specific types of healing practices:

a. Education: Government-mandated educational standards for the multidisciplinary and the broad domain of healing arts can be misleading and unrealistic and can decrease consumer access to practitioners that do not abide by governments' mandates. Attempts

to regulate may involve setting arbitrary numbers of classroom hours at selected types of educational institutions with the receipt of conventional types of degrees, but many forms of natural healing cannot be confined to traditional learning environments or classroom or textbook training. Practitioner effectiveness may depend on inherent giftedness in the healing art. Skills may be acquired by mentoring with an individual, self-study, or other unconventional methods. Attempts by the government to quantify effective preparation needed for a particular healing art may restrict the pool of practitioners and may only serve to eliminate some of the most effective healers. Government mandates may miss some of the more intuitive or spiritual dimensions of healing skills which may not be easily defined or tested.

* Governments should allow practitioners to practice regardless of their education and training as long as they practice within reasonable conduct guidelines and provide consumers with an informed environment. This will ensure maximum consumer options.

b. Innovation: Regulation that restricts health care practice to one group and to one standard of care can decrease incentive for innovation. The healthcare field needs healthy competition in the market place and needs the freedom to expand and develop as understanding of healing grows.

* No restrictions should be put in place regarding dissemination of new ideas and information if there is no imminent risk of harm and there is an informed consumer environment.

c. Preservation of Knowledge: Health care regulation must always safeguard against the elimination of age old wisdom and knowledge of healing.

* Preservation of wisdom is accomplished only in a free and uncensored society.

d. Cooperation among Practitioners: Health care regulation that promotes turf battles instead of an interdisciplinary environment decreases the potential for cooperation and exchange of information among practitioners. Practitioners practice in fear of being charged with the practice of medicine without a license or in fear of losing their existing license for practicing outside of a defined scope.

* The least restrictive means of communication should be used to promote acknowledgment and acceptance among practitioners and promote professional coordination, cooperation and free flow of information.

e. Consumer Decision-making: Occupational regulations that limit consumer options take away important rights and motivations of consumers to decide their own healing path.

* Consumer decision making should be encouraged and regulation should support the fact that consumers that participate in their own health care decisions thrive more and have better health outcomes.

Re: Federal Regulations of Communications, Products, and Devices:

14. Federal regulation of communication, drugs and devices is not the least restrictive means of health care regulation and can negatively impact consumer options when used as the sole means of regulation. For example, the federal definition of a drug is the most restrictive type of regulation possible for health care products. Federal law defines drugs broadly to include any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease. Substances that are defined as drugs cannot be used without FDA approval and the approval process involves lengthy expensive studies economically prohibitive for the general public. This law puts an unreasonable burden of proof on the public and outlaws the use of all healing agents that have not been proven safe by the government, even when there is no documented imminent risk of harm and even when the consumer is properly informed. This drastically reduces consumer options and choice of treatments.

15. The Dietary Supplement Health and Education Act is a strong positive reform of the Federal Food, Drug, and Cosmetic Act that protects the right of access of consumers to safe dietary supplements used to promote wellness.

16. The DSHEA amended the definition of food to include dietary supplements; however, the definition of drug remains and has yet to be reformed. This reform is needed to secure the maximum number of options for all consumers.

In Summary:

I. State and federal governments must be vigilant during health care reform to preserve the balance between government regulation and an individual's right of self determination and right of choice.

II. Existing regulatory health care statutes should be reviewed and revised to acknowledge and promote the use of the broad domain of healing arts and trades in a nonexclusive manner by all consumers and by all professions both licensed and unlicensed, thus creating the widest range of choices for consumers.

III. A regulatory framework should be utilized that embodies the least restrictive means of regulation, and that provides an informed consumer environment and a system for consumer recourse in the event of a complaint. For state regulation, The Minnesota Complementary and Alternative Health Care Freedom of Access Act of 2000 can be referred to for conceptual planning. For federal legislation, bills amending the definition of the word drug can be reviewed for conceptual planning.

IV. Government should look to the future and create laws that allow for the greatest amount of innovations and that ensure freedom of consumer access to all health care options.

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WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE

ORAL PRESENTATION

On Behalf of
THE ASSOCIATION OF PHYSICIAN ASSISTANT PROGRAMS

February 23, 2001
Presented by
Brenda J. Jasper, M.Ed., PA-C
Chair and Assistant Professor
University of Maryland Eastern Shore
Princess Anne, Maryland

On behalf of the Association of Physician Assistant Programs (APAP), the only national organization in the United States representing physician assistant (PA) educational programs, I thank the Commission for the opportunity to share our educational model as an example for integration of complementary and alternative medicine (CAM) into existing educational programs. APAP's mission is to assist physician assistant educational programs in the instruction of highly educated physician assistants in numbers adequate to meet society's needs. Physician assistants are health care professionals licensed to practice medicine with physician supervision. As part of their comprehensive responsibilities, PAs exercise autonomy in conducting physical exams, diagnosing and treating illnesses, ordering and interpreting tests, counseling on preventive health care, assisting in surgery, and in most states, writing prescriptions.

The PA profession grew out of a recognized need for a health professional trained in the medical model who would work with physician supervision to extend patient access to care, particularly in medically underserved areas and

health professions shortage areas. The curriculum in PA educational programs is geared toward primary care and focused to provide the appropriate education in an intensive and uniquely designed manner. The profession has retained this commitment to the medical educational model and to team practice with physician supervision since its inception in 1966, thirty-five years ago.

Physician assistant programs are accredited by the independent Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), composed of representatives from the American Medical Association, the American Academy of Family Physicians, the American College of Surgeons, the American Academy of Pediatrics, the American College of Physicians, the Association of Physician Assistant Programs, and the American Academy of Physician Assistants. Although all accredited PA programs must meet the same rigorous educational standards, they have the flexibility to offer a variety of academic degrees. Graduation from an accredited PA educational program is the definitive credential.

Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for recertification every six years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure.

What a physician assistant does varies with training, experience, and state law. In addition, the scope of the PA's practice corresponds to the supervising physician's practice. In general, a physician assistant will see many of the same types of patients as the physician. The cases handled by physicians are generally the more complicated medical cases or those that require care that is not a routine part of the PA's scope of work. Referral to the physician, or close consultation between the patient, the PA, and the physician, is done for unusual or hard to manage cases. Physician assistants are taught to "know our limits" and refer to physicians and other health professionals appropriately. It is an important part of PA training.

Physician assistant education is characterized by an intense, yet practical curriculum, with both didactic and clinical components, ranging from 25–27 months, with a minimum of two years of prerequisite education. PA education is tightly structured and focused, and recognized by many as highly innovative, efficient, and effective. It is competency-based, meaning that students must demonstrate proficiency in various areas of medical knowledge and must meet behavioral and clinical learning objectives. The typical PA student has earned a bachelor's degree and has an average of 48 months of health care experience prior to program admission. The first year of PA education provides a broad grounding in medical principles with a focus on their clinical applicability. This didactic curriculum typically consists of coursework in the basic sciences, including anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory sciences, behavioral sciences,

and medical ethics. In the second year, students receive hands-on clinical training through a series of clerkships or rotations in a variety of inpatient and outpatient settings. Rotations include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry. Physician assistant students complete on average over 2,000 hours of supervised clinical practice prior to graduation. The accreditation standards have historically embraced the latest innovations and trends in medical practice over the years, to add to the rigorous curricula content areas such as health promotion and disease prevention, geriatrics, and evidence-based medicine. Although intense, the standard educational model allows for flexibility of individual programs, as does the actual clinical practice of the physician assistant. PA education can serve as a model for a balanced curriculum, between theory and practice. This model can easily introduce trained health care providers in a relatively short period of time. We look forward to future opportunities to share our experience as an innovative model for medical education that has achieved integration within the mainstream of primary health care.

Association of
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WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE

ORAL PRESENTATION

On Behalf of
THE ASSOCIATION OF PHYSICIAN ASSISTANT PROGRAMS

February 23, 2001
Presented by
Emily WhiteHorse, BS, PA-C
Assistant Professor
Philadelphia University

I am here on behalf of the Association of Physician Assistant Programs (APAP), and as a PA practitioner and educator who has embraced the inclusion of CAM for over 10 years, it is truly an honor to be here today in the presence of this distinguished committee.

A few facts about my profession: there are now approximately **40,000** practicing PAs, **10,000** PA students, and **126** accredited PA educational programs. Over the past five years alone, the number of PA programs has doubled.

As mid-level health care practitioners, we come face to face daily with patients who use or are interested in CAM. Presently, our biomedical educational model does not include CAM as an accreditation standard although in 1998, 52 percent of 80 programs that responded to a survey indicated that they included instruction on CAM.

In PA education, we have struggled with whether or not to include CAM. However, with the ongoing patient demand and use of CAM, the questions have now become: How do we include it in an already intensive educational program, and How do we determine what information is needed.

Evidence supports a contention that there is a fundamental change occurring in the values, beliefs, and expectations of the people who make up our culture regarding health, healing, and disease. All health care systems are developed around and function from an explanatory model, which is culturally bound and based on the overall beliefs and values that are representative of the dominant culture. Clearly, though, we are on the brink of change: our culture is redefining its beliefs and expectations about health care, health care practitioners and the entire health care system. It appears that this paradigm shift represents a shift in worldview from a mechanistic, reductionist one to a holistic one.

While it is important to focus on identifying and understanding CAM, we also need to ask the questions: What is it that our patients really want from us as

providers and from our health care system? And, if they are asking that we be more holistic in our overall approach to health and illness: Does our job as medical educators become the integration of holistic concepts and principles into the educational model of health care practitioners, concepts which include CAM?

A first step in addressing these questions could be the creation of a committee or task force to address these and other concerns facing the education of medical practitioners as a whole. In the spirit of holism and cross-disciplinary cooperation, this task force could bring together educators from various medical professions, as well as medical and CAM practitioners, with the goal of establishing minimum requirements for all of medical education regarding CAM. A need for clear and consistent guidelines and consensus seems warranted.

All of this, however, rests upon whether CAM is included as an acceptable standard of care in our health care system. Without support from organizations like NIH and this commission, and without continued national and government support and recognition of the potential CAM holds, both positive and negative, it remains uncertain whether CAM can be included in medical education, as an accreditation standard, in program curricula, or on board exams. As a result, future practitioners will continue to struggle in the same way that we as practitioners struggle today with the lack of formal training regarding CAM.

In closing, I would like to thank the committee for the opportunity to speak on behalf of the Association of Physician Assistant Programs, and to also offer our assistance and cooperation in future deliberations, committees, or organizations regarding this important issue.

White House Commission on Complementary and Alternative Medicine
Testimony
Brian J. McAulay, D.C., Ph.D., interim president
Sherman College of Straight Chiropractic

Thank you for this opportunity to share information with you about the state of chiropractic education and how the profession can best serve the American people. As a licensed doctor of chiropractic, I was in private practice for 13 years in Pennsylvania. I also hold a Ph.D. in organization theory and management from Temple University in Philadelphia. I have served as a faculty member for many years educating students in chiropractic technique and philosophy, as well as undergraduate and graduate business students. Today, I serve as interim president of Sherman College of Straight Chiropractic in Spartanburg, South Carolina.

Chiropractic is a 62,000-member strong profession in North America with licensed doctors of chiropractic serving the population in all 50 states, U.S. territories and Canada. It is the nation's third largest primary health care profession, after medicine and dentistry. Founded in 1895 in the United States, the profession has grown throughout the world and doctors of chiropractic today practice on every continent. The public's use of chiropractic has grown dramatically in recent years with 37 percent of the population having sought chiropractic care. Annual visits to chiropractors exceed the visits to any other practitioner of alternative health.

Chiropractic is based on the premise that the body's innate recuperative capabilities are affected by and integrated through the nervous system. Chiropractic is a science and art devoted to the location, analysis and correction of vertebral subluxations, misaligned vertebrae of the spine that interfere with the ability of the nervous system to coordinate and control the organs and systems of the body. Many health-conscious people make chiropractic a regular part of their health care regimen, along with such sound practices as exercise, good nutrition, stress management and regular medical check-ups. Chiropractic is a separate and distinct field that does not compete with the practice of medicine or the use of alternative therapies.

According to the U.S. Department of Labor, employment of chiropractors is expected to grow faster than the average for all occupations through the year 2008 as consumer demand for alternative health care continues to grow. The education required to become a licensed doctor of chiropractic is rigorous, similar to that required for a medical doctor. All students entering chiropractic college must have completed 90 semester hours of prerequisite courses at an accredited undergraduate college. Once enrolled in chiropractic college, students complete approximately 4,600 hours of instruction. This is typically accomplished through approximately 13 academic quarters requiring three and a half years of full-time study, or the equivalent of five years of study on a traditional semester system. Upper-quarter students complete a one-year internship in a college-based chiropractic health center where they provide comprehensive chiropractic care to the public under the supervision of licensed doctors of chiropractic.

There are currently 16 chiropractic colleges in the United States and all are accredited by the Commission on Accreditation of the Council on Chiropractic Education, a professional accrediting body recognized by the United States Department of Education. The process for

receiving CCE accreditation is similar to that required by the regional and professional bodies that accredit other institutions of higher education.

The chiropractic profession has grown and prospered in this country based on the public's demands for these important services. The profession has traditionally received little or no federal support. I recommend the Commission pursue the following initiatives to ensure the availability of quality alternative chiropractic care for the American public:

- Formally recognize the value and appropriateness of chiropractic's meta-therapeutic health care paradigm that focuses on enhancing performance and function, rather than treating disease.

- Allocate federal funds for chiropractic college-based research programs. The nation's top 50 medical schools alone in 1999 received more than $6.5 billion in research funding through the National Institutes of Health. Supporting the wellness and preventive health paradigm of chiropractic research that explores ways to help people avoid serious health problems and enjoy greater function and performance (compared to traditional biomedical research that is treatment- and condition-based) would help reduce our nation's dependence on expensive medical interventions once disease states and conditions have manifested.

- Provide student loan and debt relief for chiropractic college graduates who practice in underserved areas of the country, or care for underserved segments of the population.

- Provide direct federal funding to support chiropractic college education with investments in facilities, training, instrumentation and technology, as is currently done in the nation's medical schools. Chiropractic colleges must benefit from such national initiatives as Congress' approved doubling of the NIH budget from 1999 to 2003 to ensure quality education of a far greater spectrum of the nation's health care providers.

THE NEW YORK INSTITUTE OF CHINESE MEDICINE

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Dear Honorable Members of the White House Commission on Complementary and Alternative Medicine Policy.

Please allow me to introduce myself. I am Dr. Chi Chow, a licensed acupuncturist practicing in New York. I am the founder and current President of the New York Institute of Chinese Medicine located in Mineola, New York. I am also a former Commissioner of what is now ACAOM, the Accreditation Commission for Acupuncture and Oriental Medicine, and a former Board Member of the Illinois State Acupuncture Association. I was originally trained as a Western M.D. in China, and have practiced and taught both Western and Chinese Traditional Medicine for more than 30 years.

As someone who has an extensive background in both Western and Chinese medicine, and who has been involved in training practitioners of both disciplines, I would like to emphasize to you that, while complementary in many ways, Western and Eastern medical practice are very different in approach. While it is true that a Western M.D. would not require too much training in order to locate acupuncture points or to insert needles in the proper way, a much deeper level of understanding is required to perform a proper diagnosis and to outline a proper treatment plan according to Traditional Chinese Medicine theory. Without this deeper grounding in TCM, the more superficial knowledge of needling and of herbs is at best ineffective and at worst can be dangerous to the patient. I only have to cite the recent highly-publicized case of a European M.D. inadequately trained in Chinese Herbology causing harm to his patient by administering herbs in quantities that would never have been sanctioned by a qualified Chinese herbalist.

The standards of training in our profession in the U.S. are promulgated by ACAOM, the Accreditation Commission for Acupuncture and Oriental Medicine, which is the only national accrediting agency recognized by the U.S. Department of Education for the approval of programs preparing acupuncture and Oriental medicine practitioners. The amount of training that is required to become a competent entry-level practitioner of acupuncture or Oriental medicine has been exhaustively studied and has been set by ACAOM at a minimum of 1725 hours (or about three academic years) for acupuncture and at a minimum of 2175 hours (or about four academic years) for Oriental medicine. In addition, in most states students are required to pass a comprehensive certification examination in acupuncture before receiving their license to practice.

ACAOM and the various colleges of acupuncture and Oriental medicine are also concerned about improving educational opportunities for practitioners. To this end, doctoral level programs, which will confer a Doctor of Oriental Medicine (D.O.M.) degree, are currently being prepared by accredited colleges. These programs would require a total of 4000 clock hours of professional education including the educational requirements of the masters degree.

When these programs are compared with the 300-hour distance learning programs that allow M.D.'s to practice acupuncture in most states, you can see the huge discrepancy in training that we are dealing with. And make no mistake about it, this discrepancy has serious consequences for the U.S. consumer of health care services. At best it can lead to a misperception of the efficacy of acupuncture and Oriental medicine, since treatment by an undertrained practitioner, M.D. or not, is not likely to have any good result. At worst, as already mentioned, it can lead to injury and even loss of life.

Because of this, I feel that uniform national educational standards need to be put in place to ensure that patients receive care from well trained professionals. At minimum, these standards should reflect those put forward by ACAOM. At the same time, guidelines should be adopted which would allow only practitioners meeting the educational standards to use the words "acupuncturist" and "Chinese herbalist" in their advertising.

Western medicine has its strengths, and our society cannot survive without it. But our society should not suffer from improper or ineffective Oriental medicine treatments performed by unqualified and undertrained Western practitioners. Only those individuals who have been educated and tested under the highest standards in the profession should be allowed to practice acupuncture and other forms of Oriental medicine. Both Western and Oriental medicine can be successfully integrated with the cooperation of well-trained practitioners from both fields.

華美中醫學院
AMERICAN COLLEGE OF ACUPUNCTURE & ORIENTAL MEDICINE

December 18, 2000

Dear Honorable Members of the White House Commission on Complementary and Alternative Medicine Policy,

Please allow me to introduce myself. I am Dr. Shen Ping Liang, a licensed acupuncturist practicing in Houston, Texas. I am currently one of the Executive Directors of the Council of Colleges of Oriental Medicine, Chairman of the Education and Academic Achievement Committee and Chinese Advisory Council of the American Association of Oriental Medicine, and President of the nationally accredited school American College of Acupuncture & Oriental Medicine located in Houston, Texas. I am also a former Board Member and founding Board Member of the Texas State Board of Acupuncture Examiners.

As one of the leaders in the Oriental Medicine community, it is my understanding that public hearings, sponsored by your Commission, have been taking place around this nation. During these hearings, the focus has been on the issue of qualifications and credentials that should be required of a practitioner of acupuncture and other forms of Oriental medicine. I appreciate the opportunity to add my opinion, based on nearly thirty years of experience in the field, to this dialogue.

Educational Qualifications of Oriental Medicine Practitioners

An extensive and comprehensive education is the key to ensuring that an individual is qualified to practice in any area of medicine, including Oriental medicine. The highest educational standards in Oriental medicine are currently promulgated by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), the only national accrediting agency recognized by the U.S. Department of Education for the approval of programs preparing acupuncture and Oriental medicine practitioners.

9100 Park West Drive • Houston, TX 77063 • Tel: (713) 780-9777 • Fax: (713) 781-5781

The forty three member schools of the Council of Colleges of Acupuncture and Oriental Medicine have been accredited by ACAOM or are candidates for accreditation by that agency. These member schools have a Master level Oriental medicine programs which, on average, require between 2,400 and 3,000 clock hours (between three to four calendar years) for completion. Such training includes extensive practical training in a clinical setting. It is my opinion that these qualifications are the *minimum* required in order to best protect the health and safety of the patients who choose Oriental medicine to alleviate their particular health condition.

The number of practitioners of Oriental medicine with an education meeting these standards is estimated to be 20,000. It is also estimated that an additional 10,000 students are currently enrolled in these schools which produce 2,000 to 3,000 graduates per year. Most states which regulate acupuncturists require that individuals pass a set of national examinations given by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) prior to receiving their license to practice.

Although this level of education for practitioners has produced highly skilled practitioners, as reflected by low number of professional liability claims in this area, the accreditation commission, the academic community, and the professional community are constantly striving to improve educational opportunities for practitioners. Besides ongoing continuing education requirements, doctoral level programs which will confer a Doctor of Oriental Medicine (D.O.M.) degree are currently being developed by accredited colleges. The D.O.M. program would require a total of 4000 clock hours of professional education including the educational requirements of the master degree.

Current Lack of Training in the M.D. Community

In contrast, most states allow licensed medical doctors (M.D.'s) to practice acupuncture and other forms of Oriental medicine without any specific training. The most popular acupuncture program for M.D.'s is a distance learning course given by the University of Southern California at Los Angeles (U.C.L.A.). It requires only 300 clock hours of instruction including videotaped instruction and practical training on weekends. Chiropractors can practice in some states with even less training than is offered by the U.C.L.A. course. This lack of training among M.D.'s and chiropractors represents a serious danger to public safety. For example, the recent FDA guidelines prohibiting the use of certain Chinese herbs resulted from an herbal overdose given by an M.D. in Europe

who was not adequately trained in Chinese herbology. Many M.D.'s however, have recognized that they need the comprehensive training offered by accredited colleges of Oriental medicine, and have therefore obtained their Oriental medicine degree from these institutions.

Recommended Standards

In order to best serve the public, the federal government should consider these recommendations:

1. Develop a uniform professional educational standards to ensure that patients will receive care from well trained, qualified practitioners.

The standards should be the same as those used successfully to train most of the current practitioners of Oriental medicine, namely, the standards developed by the Accreditation Commission for Acupuncture and Oriental Medicine. Practitioners with less training pose a real danger to the public, and may ultimately destroy the profession by ruining its credibility.

2. Develop a uniform definition of "acupuncturist" which incorporates the educational standard.

Such definition would include the ACAOM educational standards and passing of the NCCAOM national examinations/and or licensing from the state acupuncture board or other state regulatory body. Practitioners without such credentials should not be allowed to use the title "acupuncturist," even if they practice acupuncture on their patients.

3. Develop uniform advertising guidelines for practitioners of acupuncture.

Only practitioners who meet the above definition of acupuncturist should be allowed to advertise their practice as acupuncturists. If the practitioner practices in a state which licenses acupuncturists, the license number should be required on all such advertising. Following such advertising guidelines will reduce the amount of potentially deceptive advertising in this field.

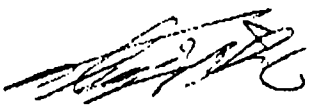
Conclusion

Western medicine has its strengths, and our society cannot survive without it. But our society should not suffer from improper or ineffective Oriental medicine treatments performed by unqualified Western practitioners. Only those individuals who have been well educated and tested under the highest standards in the profession should be allowed to practice acupuncture and other forms of Oriental medicine. Both Western and Oriental medicine can be successfully integrated with the cooperation of well trained practitioners from both fields.

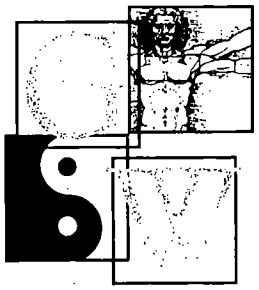
The White House has given greater attention to alternative medicine over the last eight years. It has recognized that natural health care such as Oriental medicine, can give excellent results at a lower cost with few side effects. We believe that following these recommendations will ensure the greater health and safety of the patient population as the profession of Oriental medicine continues to grow.

The twenty first century requires *greater* knowledge and specialization, not less, and Oriental medicine is no exception. Let's keep the standards high, and the public will benefit from a health care system of the highest quality.

Sincerely,



Shen Ping Liang, Ph.D., Licensed Acupuncturist
President, American College of Acupuncture
& Oriental Medicine



Center for
Integrative Medicine
Medicine for the 21st Century

A PILOT PROJECT TO TRAIN MEDICAL SCHOOL STUDENTS IN THE PRINICPLES AND APPLICATION OF CAM:

MEDICAL SCIENCE AND BEYOND, TEACHING THE UNCONVENTIONAL UNCONVENTIONALLY

The Center for Integrative Medicine (CIM) at the George Washington University Medical Center has developed a program, "Medical Science and Beyond: Teaching the Unconventional Unconventionally" which addresses the following problem:

Traditional and current medical education at The George Washington University and medical schools around the country produce physicians who are highly-trained in the allopathic biomedical model but who lack knowledge of the multitude of complementary and alternative medical modalities (CAM) practiced in the United States and around the world. Physicians who are not equipped to discuss and evaluate such practices with their patients are not fully able to address the comprehensive medical needs and preferences of those they treat.

Through three learning modules, Experiential, Didactic, and Participatory, a group of medical students (class of 2004) will be exposed to the philosophy and practice of complementary and alternative medicine. In the first module, students will become patients of the Center, learning to incorporate complementary treatments into their own lives. In the Didactic module, consisting of a total of fifteen lecture/discussions and clinical observations, actual patients of the CIM will join the students, lending their unique perspective on comprehensive care and treatment. The third module, Participatory, will provide a practicum for students in the Center for Integrative Medicine. They will observe experienced providers and learn interviewing and assessment skills to enable them to integrate complementary and conventional medicine.

Students will demonstrate mastery of CAM through a series of written and interactive exercises. The program evaluation will assess the quality of the students' learning and will also consider whether the use of CAM by the students themselves has maintained their physical and emotional wellness throughout the course of medical school.

The goal of the Project will be the incorporation of CAM into the core curriculum of the George Washington University Medical School and replication of the program in other settings around the country.

The Project is funded by a three-year grant from the US Department of Education – Fund for the Improvement of Post-Secondary Education, which began in September 2000

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February 2001

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Susan Bonfield Herschkowitz

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Oral Testimony of
Susan Bonfield Herschkowitz

White House Commission
on Complementary and Alternative Medicine Policy

Unites States Department of Health and Human Services
Washington, DC

February 23, 2001

My gratitude to the Commission for giving me this opportunity to speak. I used an innovative chiropractic method, called Directional Non-Force Technique, and acupuncture to cure chronic obstructive pulmonary disease, vertigo, allergies, hyperthyoidism and Bell's palsy. Natural medicine enabled me to survive and speedily recover from a recent, life-threatening medical crisis during which physician prognoses were extraordinaily grim: brain damage, permanent physical disability, even death.

It is welcoming that conventional physicians are beginning to embrace and even be trained in natural medicine. However, it is extremely misguided if the conventional medical community sees natural therapies through the prism of conventional medicine. There are major differences between the two that must be acknowledged and incorporated into current and future approaches to our nation's health care:

* **Natural medicine is not one size fits all medicine**. Unlike conventional medicine, natural medicine tailors remedies and treatment specific to each individual patient - using information provided by the patient's body.

* **Natural medicine does not treat just a disease**, but examines and treats the patient's entire body. Conventional medicine only looks at the specific disease and the specific part of the body affected by that disease.

* **Natural medicine heals the body through a process that occurs over time** because it taps the body's own abilities to heal. This process requires patience from the patient.

* **Natural therapies are most effective when used in partnership with other natural therapies**, especially in patients with troublesome or chronic medical problems. This partnership enhances the ability of each therapy to succeed in its healing task, and strengthens the body with more natural healing tools.

* **Natural medicine is far less experimental than conventional medicine.** There are no invasive procedures used **on** the body or experimental drugs tested **in** the body. The human body provides the clues of a disease and solutions to its treatment.

* **Natural medicine is low-tech, and, therefore, less expensive** than conventional medicine. It only appears to cost more because it is rarely covered by health

insurance.

* **Natural health providers trained in Western herbs have the ability to pre-test the safety and effectiveness of herbal remedies** through non-invasive, painless and simple techniques that use the patient's own energy. Unlike conventional medicine, an herb does not have to be ingested to discover whether it is safe and effective.

Unfortunately, the conventional medical community remains skeptical and dismissive of natural medicine's benefits. The Commission can erase this skepticism by becoming energetic partners with natural health care providers and their respective professional associations during its deliberations. Natural medical experts have the knowledge and skill needed by the Commission to complete its work. Their professional associations work diligently to develop standards of training and care. The Commission would serve its purposes more effectively and wisely by tapping into this wealth of experience.

Thank you.

Susan Bonfield Herschkowitz

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Testimony of
Susan Bonfield Herschkowitz

White House Commission
on Complementary and Alternative Medicine Policy

Unites States Department of Health and Human Services
Washington, DC

February 23, 2001

My gratitude to the Commission for giving me the opportunity to share with you my personal experiences with alternative and natural medicine.

The first day of the rest of my life arrived October 29, 2000. On that day, for the first time in nearly 14 years, I took my first full, deep, complete and normal breathe of air. On that day, my chronic obstructive pulmonary disease ceased to exist.

Let me state most emphatically and unequivocally: **alternative and natural medicine saved my life**. Not once, but twice. Without alternative and natural medicine, I would have faced the following prospects, both quite unappealing to me: 1) an extremely poor quality of life where I would be unable to perform minimally any activities of daily living despite use of multiple conventional prescription medications; and, 2) death at an age far earlier than I would have preferred. Without alternative and natural medicine, I might have met the extraordinarily grim prognoses expected by conventional physicians during a more recent grave, life-threatening medical crisis.

My experience with alternative and natural medicine has nothing to do with miracles. It is, however, a fascinating journey into the intricacies of the ultimate machine we call the human body, a journey that for me has been tedious, educational, rewarding and, ultimately, life-saving.

Curing COPD, Vertigo, Allergies And Other Medical Problems

On November 30, 1986 I developed what the medical community calls "chronic obstructive pulmonary" disease, also considered an "autoimmune disease" or a "dysfunction of the autoimmune system". In short, I developed the most severely disabling asthma that an asthmatic can have. I had been away on business for over three months and had subleased my apartment. Unfortunately, my subtenants did not take good care of my apartment. When I returned home from my travels, I had a massive allergic reaction to the mess they left behind and to the cleaning agents I used to clean my apartment.

Before I stepped through the door of my apartment on that fateful day, I was an energetic and athletic woman. After this massive allergic reaction, I did not have the pulmonary capacity to walk - even crawl - across a room. Performing any activity or task of daily living was simply out of the question. My lungs were filled continuously with mucous common in asthmatics. Additionally, I had to contend with typical asthma attacks, which only exacerbated my already debilitating medical condition.

Accompanying this severe asthma was equally disabling back problems. Despite growing up with a slight double scoliosis, I was quite athletic and I never had back problems until I was stricken with this chronic obstructive pulmonary disease. But, as I would discover in my journey with alternative and natural medicine, my slightly twisted spine would be the backbone to the causes of my disease and to my recovery.

Soon after I became ill, I sought the medical assistance of two conventional physicians, one here in Washington, DC, and my trusted doctor in New York, who was my personal physician when I lived in that city. My New York doctor, whom I admire and respect, is also a pulmonary internist, and an expert on diseases that affect the lung. After examining me and prescribing additional medications to those previously prescribed to me, my New York doctor could not believe that with asthma so life-threatening I had not been hospitalized for this condition. He also stated to me that I would be on prescription medications for the rest of my life. I remember so clearly my intense, visceral reaction to his statement. I knew there had to be a better way. I had no intention of being on medications for the rest of my life, drugs that would do little to improve or restore the quality of my life.

Here is a list of medications prescribed to and used by me on a daily and regular basis: inhalers, including Proventil (albuterol), Atrovent (ipratropium bromide), Intal (cromolyn sodium), and Asthmacort (a steroid); and oral medications, including Theo-Dur (theophylline), Proventil (albuterol) and prednisone (a steroid). These powerful medications were one standard regimen prescribed by conventional doctors for an asthmatic with my severe symptoms.

Despite use of all these medications, I still could barely walk across the room. My pulmonary function did not improve all that much. Having anything close to my normal life was out of the question. I had no choice but to take a leave of absence from my personal and professional lives.

An unexpected event changed my circumstances. In February 1988, my car was struck by another car. Once again my life would change. To treat the subsequent injuries from the accident, I returned to my chiropractor, who practices a very innovative chiropractic method called Directional Non-Force Technique (DNFT). Several months before the accident, I sought treatment from the same chiropractor for my asthma and back problems. I did not experience much progress in my treatments at that time. For some unknown reason, however, the additional physical trauma caused by the accident triggered my body to respond differently to my chiropractor's care.

Let me briefly describe the uniqueness of Directional Non-Force Technique chiropractic care. Developed over 60 years ago, DNFT uses a leg reflex and leg measure to detect and check the presence, location and direction of nerve interference and "subluxation", or misalignment. To use DNFT language, a gentle thumb thrust then is used to correct or "adjust" this misalignment. This technique allows the body itself to identify misalignments in vertebrae, ribs, muscles, discs, cranials, soft tissues, extremities and some ligaments. The chiropractor adjusts only what the leg reflex identifies or "shows up" in the patient's body. There is no twisting, jerking or cracking of the spine.

For most patients with more simple, localized neck or back problems, DNFT quickly can eliminate those problems in a few visits. However, my medical problems are far more traumatic and complex than the typical DNFT chiropractic patient. As a result, my DNFT experiences have been more challenging and long-term. As I describe further, those experiences have been powerful and overwhelmingly successful. Having used other chiropractic methods in the past, I consider DNFT to be the most gentle and effective chiropractic technique being practiced today.

In my 10th grade biology class I learned how the skeleton is one critical element of the human body. It was the structure through which all the body's biochemical and nervous systems networked and to which all the muscles and ligaments were attached. Just like a machine with multiple gears, both simple and complex, all of the body's functions work at their optimal best when the skeleton is aligned properly. And like a machine that does not work or works less efficiently when some of its gears are out of alignment, the human body reacts similarly when the skeleton is not aligned properly. Disease is the result of this inefficiency.

Within six weeks of my return to my DNFT chiropractor, I no longer needed most of my medications. In those six weeks, my body began to reject outright the more serious medications, particularly the harsh oral medications. With guidance from my conventional doctor, my doses of those medications were reduced and eliminated in those six weeks. The only medications I continued to use were two inhalers: Proventil and Intal. However, normal pulmonary function had not returned.

Then in October 1990, I faced yet another medical problem. I suddenly developed vertigo.

Once again a Washington, DC physician treated me for the vertigo by prescribing a Transderm Scop (scopolamine) patch. After three months of treatment, this physician suggested to me the following: 1) I may have a brain tumor; and 2) my back problems were a figment of my imagination. Once again, I had that intense, visceral reaction that instinctively said "no way".

It was then I discovered acupuncture and its amazing power to heal.

Several years earlier I had clipped and saved a Washington Post article describing a highly-regarded Washington acupuncturist, familiar to many Washingtonians, who used Chinese medicine to treat recovering addicts and AIDS patients. Once clipped, the article remained pinned in a prominent location on my office bulletin board.

Feeling I had absolutely nothing to lose, I called this acupuncturist and explained my situation. He said he could help.

I began my first acupuncture treatment in early January 1991. The results were more than impressive: for the first time since that fateful November day in 1986, I felt a buoyancy in my lungs I had not felt in over four years. I knew I had found another part of the puzzle to my complete recovery, a perfect partner for the continuing DNFT chiropractic care I was receiving.

For a new patient, it takes approximately six acupuncture treatments to affect the symptoms of a disease. After six weeks of acupuncture treatments, I decided to take the plunge and remove the Transderm Scop patch infusing me with the vertigo medication.

The physician who treated me for the vertigo neglected to share with me a critical piece of information about Transderm Scop: it was an addictive medication. Not knowing the addictive qualities of scopolamine left me totally unprepared for my body's response when I eliminated the medication: I experienced all the nausea, cold sweats and other wickedly unpleasant symptoms commonly associated with drug withdrawal. Needless to say, I was stunned and quite furious that I was going through drug withdrawal. It should not surprise you that, since this experience, I have never recommended this particular physician to anyone.

At this point, the journey to my recovery took a new direction.

As I mentioned earlier, DNFT chiropractic uses a unique method to identify and correct nerve interference and misalignments in the body. And the body tells the chiropractor what needs to be adjusted. Immediately after I recovered from the drug withdrawal, my chiropractor identified numerous misalignments in my neck and spine that previously had not "shown up", as it is termed in DNFT. After correcting these misalignments, my vertigo disappeared. Two weeks later I again experienced more vertigo. I visited my chiropractor, she identified some new misalignments in my neck and spine, and once again corrected them. I have not had vertigo since.

Several months later, my acupuncture treatments became more aggressive, with extensive treatment specifically for the back (using a technique called "back-shu", which places the needles two fingers width away from the spine) and lung, with additional attention paid to kidney, spleen, liver and heart points. The aggressive acupuncture treatments accelerated the progress in my DNFT treatments, when, in July 1991, my chiropractor found my lumbar vertebrae twisted in an unusually odd and unexpected direction. This big event would be the first of a series of major skeletal changes that would typify and mark the pattern of my recovery. By November of that year, the entire left lobe of my lung returned completely to normal function.

As I continued aggressively with both the acupuncture and DNFT chiropractic over the ensuing years, my lung function returned to normal in a very specific, consistent pattern throughout my recovery. When it did occur, the area of my pulmonary system that returned completely to normal was always 50% of the area that remained obstructed with the COPD. Once a section of my lung returned to normal, I no longer experienced any chronic obstruction or asthma in that section. When my chronic asthma was exacerbated, the exacerbation affected only the area of my pulmonary system that remained in the grips of the COPD. Sections of my pulmonary system returned to normal in: November 1991; October, November, and December 1992; February 1999; September 1999; and, lastly, twice in October 2000. Shifts in my lumbar vertebrae were critical to my pulmonary function returning to both right and left lobes and most of my trachea; shifts in my cervical vertebrae (C1, C2, and C3) were key in pulmonary function returning to the upper right side of my trachea.

The path I followed to cure my chronic obstructive pulmonary disease also has had some unexpected, yet positive consequences for me. I used to suffer terrible allergies during those peak Spring and Summer seasons of flower and tree growth. Now I watch other people suffer while nary a sneeze, stuffy nose, or scratchy throat have I. Environmental triggers that once exacerbated my COPD (for example: smoke, certain weather conditions) are no longer problems. In fact, I relished the Arctic cold air that visited Washington during the first half of this winter - when I had COPD, I had to avoid going outside in winter weather. Now, I can breathe deeply and easily in single digit temperatures. For 21 years, I would suffer from severe bronchial infections once or twice a year. Except for three bronchial infections that developed in 1999 as a direct result of a serious, lengthy hospitalization (and for which I used high doses of Vitamin C to treat successfully the second and third of these infections that developed), I have suffered only one bronchial infection since 1989. I have used my alternative and natural health care providers to cure not only the COPD and vertigo, but to treat successfully bouts of hyperthyroidism, Bell's palsy and severe sinusitis (I added homeopathy to my program at the time I developed the sinusitis, when conventional medicine failed once again to help me).

Conventional medical wisdom about asthma dictates that asthmatics, among other actions, remove animals from the home and dairy products from the diet. I am a cat owner of over 25 years. My cats only triggered asthmatic reactions during three specific incidents since I developed chronic obstructive pulmonary disease. The last of these reactions occurred in October 1997. In response, I spent three days on a homeopathic animal desensitivity remedy, and my asthmatic reactions ceased. For the most part, my cats and my asthma have lived together quite harmoniously during this time in

my life. Additionally, I never had any asthmatic reaction to dairy products, and, until a brief period again in October 1997, I was an active yogurt and cheese eater. In that month, I suffered my first asthmatic reaction to yogurt, and I again immediately sought assistance from my homeopathist. She prescribed for me a homeopathic dairy desensitivity remedy, which I used for 10 days. Since that time, I again eat yogurt and cheese daily without any asthmatic reaction.

Aware that changes in my spine played a critical role in my recovery, one of my acupuncturists began to treat me in September 1998 with a different, more aggressive acupuncture technique to boost my healing process. This 2,000 year-old technique, called "jia-ji", has the acupuncture needles placed onto points directly alongside the spine. For me, these points tend to correlate with the most troublesome areas of my spinal curvature. The impact of the jia-ji on the DNFT chiropractic work was startling, significant and overwhelmingly positive, so much so that I regret not having started the jia-ji technique at the beginning of my journey with alternative and natural medicine. I continue the jia-ji treatments today, as jia-ji, partnered with the DNFT chiropractic, is helping to resolve my remaining, non-COPD medical issues.

Surviving A Life-Threatening Medical Crisis

In October 1999, I experienced an unexpected and grave medical crisis. I had a severe allergic reaction to a Chinese herb formula. This reaction triggered an asthma attack in the very small area of my trachea, which, at that time, was the remaining section of my pulmonary system still affected by the COPD. After going into respiratory arrest, I was placed on a respirator (on which I was kept for over 12 days) and medically paralyzed. I was in a coma for over five days. Physician prognoses were extraordinarily grim: if I did not die, I could be brain-damaged, and I might never fully regain my ability to function physically.

Needless to say, I simply failed to meet these grim expectations - and I credit my long-time use of DNFT chiropractic and acupuncture for my survival of and extraordinary speedy recovery from this life-threatening medical crisis. At the time I entered the hospital, my COPD was limited to the top eighth of my trachea on the right side - as a result, only a tiny area of my pulmonary system was affected directly by this allergic reaction. My natural approach to my health care, plus my healthy diet and extensive use of vitamins, has given me an immune system that would be the envy of the entire conventional and alternative and natural medical communities. As a result, I not only was able to survive this brush with death, but the speed of my recovery absolutely astounded the conventional physicians treating me.

After seven weeks of hospital stays, including time recovering at a rehabilitation hospital where I had to learn how to walk, talk and perform activities of daily living all over again, I returned immediately to my alternative and natural medical providers to assist in my post-hospitalization recovery. In fact, I wisely expanded my use of DNFT chiropractic and acupuncture to include massage therapy and aggressive homeopathy. The use of all these therapies significantly accelerated my post-hospitalization recovery, which included a fine motor skills physical therapy program and voice therapy.

The hospitalization aggravated significantly my slight double scoliosis, causing great discomfort and affecting my ability to walk normally. Fortunately, in about two and one-half months, the DNFT chiropractic restored my spine to the condition it was in prior to my hospitalization.

Massage therapy and a homeopathic lymph remedy enabled my body to eliminate uric acid crystals, fibrous tissue and inflammation that developed in my muscles as a result of being bedridden.

Homeopathic remedies cleansed my liver, brain and body of the effects of multiple x-rays and harsh medications given to me by the conventional doctors. Homeopathic remedies have been used to treat successfully other medical issues resulting from my hospitalization, including but not limited to: memory problems, severe eye strain and voice difficulties. I also am using homeopathy and acupuncture to attack metabolism problems I have developed as a consequence of the severe, unplanned and speedy weight loss that occurred during my 2 1/2 weeks in the intensive care unit, which shocked my metabolism into disarray.

Prior to my hospitalization, I had mild temporomandibular joint "disease" (TMJ) on the right side of my jaw, which I had expected to be resolved easily and effortlessly through my use of DNFT chiropractic and acupuncture. Occasionally my jaw on the right side would lock, but eventually my jaw would resume its ability to open fully and easily, so there was little impact on my ability to eat, brush my teeth, even yawn.

More than 12 days on a respirator changed all that: immediately after I was extubated, my jaw completely locked on both sides. Eating food and brushing teeth - even yawning - became quite a challenge. My voice was affected: not only did the intubation impact my vocal chords, but the severe lockjaw tensed muscles involved with the vocal chords. As a result, my voice was limited in its tone and range.

Once again, this severe lockjaw is being cured by my alternative and natural medical providers. Continuing with the DNFT chiropractic, I have expanded my acupuncture treatments to both left and right sides of my jaw and neck. Although I am still plagued by the severe lockjaw, I now can open my mouth enough to eat food and brush my teeth. My complete vocal range has nearly returned, and its tone has improved (although it wavers in its quality). I am hopeful that these problems will be eliminated sometime this year through my DNFT chiropractic and acupuncture treatments.

Acknowledging The Differences

It is welcoming that more conventional medical providers are beginning to embrace alternative and natural therapies. And more conventional physicians are being trained as alternative and natural medical providers. However, it is extremely misguided if the conventional medical community, especially those who are untrained and/or misinformed, sees alternative and natural therapies solely through the prism of conventional medicine. There are major differences between these two forms of medicine that must be acknowledged and incorporated into current and future approaches to our nation's health care:

* **Alternative and natural medicine is not one size fits all medicine**. Unlike conventional medicine, alternative and natural medicine tailors remedies and treatment plans specific to each individual patient - using information provided to the practitioner by each patient's body. For example, a treatment plan for one asthmatic patient may differ greatly from a treatment plan for another asthmatic patient; the treatment plan for one lupus patient may differ greatly from another lupus patient, etc. In conventional medicine, the treatment plan is dictated solely by specific protocols - not the individual uniqueness of a each patient's body. The drugs and/or procedures used in these protocols are considered effective (usually for managing disease) only after extensive, experimental, invasive testing upon human subjects. A tested drug or procedure is deemed effective only if a large population or majority of the subjects tested showed improvement. The individuality of each patient is not incorporated into

conventional medicine and its testing protocols.

* **Alternative and natural medicine does not treat just a disease**, but examines, considers and treats the patient's entire body (considered a "holistic" approach). Alternative and natural medicine considers a wide range of functions and organs within the human body that could have an impact on the initial medical problem the patient wishes to be addressed. Conventional medicine does not do this, but only looks at the specific disease and the specific part of the body (organ, gland, etc.) affected by the disease.

* **Alternative and natural medicine heals the body through a process that occurs over time**. Conventional medicine currently manages disease through medicine and/or surgery, and conventional medical providers always are seeking that "magic bullet" or "magic pill" to cure the problem. Conventional medicine encourages impatience - patients want that pill or procedure that will solve (or manage) the problem immediately. Since alternative and natural medicine taps the body's own abilities to heal, its healing process takes more time - and requires more patience from the patient.

* **Alternative and natural therapies are most effective when used in partnership with other alternative and natural therapies**, especially in patients with troublesome or chronic medical problems. A partnership of alternative and natural therapies creates a powerful synergy that enhances the ability of each particular therapy to have a greater impact on the patient's body and succeed in its healing task. Such partnerships provide the body with more natural healing tools, which strengthens the body's ability to recover from disease.

* **Alternative and natural medicine is far less experimental than conventional medicine,** as there are no invasive procedures used **on** the body or synthesized, experimental drugs to be tested **in** the body. Alternative and natural medicine relies upon the entire human body for the clues of a disease and solutions to its treatment.

* **Alternative and natural medicine, since its taps the human body's own capabilities to heal, is quite low-tech, and, therefore, less expensive** than conventional medicine. Alternative and natural medicine only appears to cost higher than conventional medicine because it is rarely covered by health insurance and involves a process of healing, rather than that "magic bullet".

* **Alternative and natural medical providers trained in the use of Western herbs have the ability to pre-test the safety and effectiveness of herbal remedies upon a patient**. Conventional medical patients are required to ingest experimental or researched medications before knowing whether or not such medications are safe and effective (for managing the symptoms of a disease). These medications are considered effective only if a large percentage of the human subjects participating in invasive experiments show improvement in their symptoms. This differs from the approach to Western plants and herbs used by practitioners of naturopathy and homeopathy. These providers have developed non-invasive, painless and simple techniques that use the body's own energy to pre-test the safety and effectiveness of every plant and herbal remedy available. The patient does not have to ingest an herbal remedy to discover whether or not it is effective. While the medical analytical literature on Asian herbs is far more extensive and detailed than Western herbs, it is imperative that such pre-testing techniques be incorporated into practitioners who distribute Asian herbs to their patients.

My resounding success using alternative and natural medicine demonstrates its remarkable and potent power to battle autoimmune diseases and other chronic and common medical disorders. The conventional medical establishment says that chronic obstructive pulmonary disease cannot be cured, but only managed with medication; I am a living, breathing example that explodes that attitude. Based on my experiences, I am confident that millions of people afflicted with autoimmune diseases including (but not limited to) diabetes, arthritis, Crohn's, lupus, fibromyalgia, as well as migraines, some fertility problems, depression, carpal tunnel and repetitive stress syndrome, morning sickness, allergies, stroke, Parkinson, multiple sclerosis and many other medical problems can be treated successfully or the patient's discomfort can be eased through a partnership of alternative and natural medical disciplines. Do not exclude cancer from these lists - I have spoken to and read about people who have used alternative and natural medicine to stem cancerous growth, with some becoming cancer-free. The possibilities of success with alternative and natural medicine is vast and largely untapped.

Unfortunately, the conventional medical community remains skeptical and even outright dismissive of alternative and natural medicine's benefits. Frankly, those attitudes, along with common conventional medical strategies that treat disease through medications and/or surgery, provide the greatest disservice to the patients conventional doctors treat. Conventional medical providers, for the sake of their patients, must reconsider these attitudes.

The Commission can erase this skepticism by becoming enthusiastic and energetic partners with alternative and natural health care providers and their respective professional associations during the Commission's deliberations. Alternative and natural medical experts have the specific knowledge and skill needed by the Commission to complete its work. Their professional associations work diligently to develop standards of training and care. The Commission would serve its purposes more effectively and wisely by tapping into this wealth of experience.

Finally, our nation's health care system, as it is designed currently, fails individuals like me who battle illness, especially chronic illness. I am not wealthy financially, and, as a single head of household, my sole income level makes me ineligible to participate in health care programs for the poor. As a result, I have mortgaged my future financial health to cover the obscene costs of my health care and other expenses incurred during my incapacity. For many years prior to my hospitalization, as an individual who does not qualify for any group coverage, I paid nearly $700 per month for health insurance, a cost that increased 43 percent after my hospitalization. Now my health insurance company has placed me in a program that imposes more coverage restrictions and provides fewer benefits, the effect of which has increased even more my out-of-pocket health care costs. Over the past several years my health insurance company has reduced significantly my chiropractic benefits. None of my acupuncture and homeopathy is covered by my health insurance. Recent, constructive health care reforms passed by Congress have failed to address the health care needs of citizens like myself, and we number in the millions. Congress must make a more vigorous and dramatic effort to make all forms of health care affordable and accessible to all citizens.

I wish to convey my profound thanks to the White House Commission on Complementary and Alternative Medicine Policy for holding this inquiry on alternative and natural medicine. This hearing serves as an opportunity for the public, medical practitioners and policymakers to understand and appreciate: 1) the valuable contribution of alternative and natural medicine to improving health care quality and individual health; and, 2) the integration of alternative and natural medicine into our health care system. More education about, research on and access to alternative and natural medicine can alleviate the suffering of millions of ailing individuals who, through conventional medicine, have been given little hope and too many powerful prescription drugs or unnecessary surgeries. I stand ready to assist the Commission's efforts in this endeavor. Thank you.

Albrecht, Joan (NCCAM)

From: Similars@aol.com
Sent: Sunday, February 18, 2001 5:13 PM
To: Whccamp (NCCAM)
Subject: Testimony

This person is on the list. # 9 — Should I answer her? — JA

FINDIN~3.DOC

Dear Staff:

I have registered with the WHC to give public comment. I have my confirmation e-mail but last time I accidentally was not included so could
you send an e-mail to me to confirm that I have a spot. My understanding is
that I will give comment on Feb. 23rd. I signed up last week. Thank you.

Also please accept the attached document as my written testimony. My oral
comments will be based on this document. Thanks again.

Regards,

Diane Miller JD
Ex. Director
National Health Freedom Coalition
New Brighton, MN 55112

FINDINGS AND RECOMMENDATIONS FOR COMPLEMENTARY AND ALTERNATIVE HEALTH CARE REGULATION

Produced by

National Health Freedom Coalition

The National Health Freedom Coalition finds that:

1. Every individual has the basic right of self-determination and the right to make their own personal choices in the process of healing. Each individual person is ultimately responsible for securing their own health and well being and making decisions to that end.

2. In order to have the right of self-determination, in the fullest sense of the word, every person has a constitutional right of access to any healing or health care practitioner, treatment, or information source they desire. This right remains, whether or not treatment options are generally accepted, well known, recognized, or researched, and regardless of a practitioner's education, training, and experience.

3. There is a broad range of types of health care practitioners and healing modalities and treatments available, be they conventional or nonnconventional, holistic, integrative, natural, or culturally specific, and many of these have provided people with profound healing effects. The individual has the ultimate responsibility for assessing whether a particular treatment or practitioner has been or is likely to be beneficial to them in their healing process.

4. Studies indicate that consumers are placing increased reliance on nonconventional healthcare providers and healing modalities to avoid the excessive cost of conventional medical services and to obtain more holistic consideration of their needs.

5. The role of the government in healthcare is to protect citizens from harm, and at the same time to protect citizen rights to individual choice and autonomy.

6. The basic right of self-determination dictates that regulations are not to be imposed that impact consumer individual rights unless they are clearly required for the safety and well being of citizens. If regulations are imposed, the following criteria should be used: 1) necessity to protect the safety and well being of citizens, and 2) use of the least restrictive means of regulation possible.

7. The least-restrictive means of regulation, balancing the role of the government to protect individuals from harm with the role of the government to protect individual autonomy and choice, should be founded on principles of a consumer informed environment and clear avenues of consumer recourse for complaints.

8. Consumers benefit from, and deserve to have, truthful information in order to make informed choices regarding their healthcare. For example, a consumer benefits when a practitioner is required, before treatment begins, to give disclosure to the consumer regarding the method of healthcare they provide and their training and experience in the health care they practice.

9. Consumers benefit from having accessible places to direct their complaints and deserve to be supported in their expectation of receiving ethical treatment and truthful information. For example, if a person has been harmed or put in the position of imminent risk of direct harm by a modality or a practitioner relationship, the government should have in place a mechanism for consumer complaint and clear grounds for disciplinary actions to correct the situation.

Re: State Occupational Regulation

10. The use of state licensure, registration, and certification to regulate health care occupations is not the least restrictive means of regulation and can negatively impact consumer options when used as the sole means of regulation. In fact, licensure is the most restrictive type of regulation, utilizing the broadest sweep of police power possible for occupations. Licensure laws typically describe an area of practice, demand particular types of education and training and use of exclusive titles for that practice, demand that the practitioner stay within the prevailing standard of care of the education and training mandated by the government for that practice, and then exclude all other persons from practicing in that area of healing.

11. Consumers are disempowered by states that only use the most restrictive means of regulation and do not provide an additional form of regulation that protects consumer options. Health-care regulations that are exclusive, that bestow ultimate power on particular types of professional and delivery systems to the exclusion of others, and that limit available healing practitioners and treatments through enforcement of exclusive and restrictive occupational laws, decrease consumer options in health care and infringe on the individual's basic right of self-determination to make choices.

12. Consumers are empowered by states that use additional least-restrictive means regulations that ensure all practitioners the right to practice and the right to use the full range of treatment methods. These states maximize consumer choice and protect the right of self-determination of the individual to make informed decisions about their health and acknowledge and respect consumer needs for meaningful information and reasonable practitioner/client relationship expectations.

13. There are recognized problems that occur when a state attempts to use exclusive and restrictive occupational regulation for nonconventional, holistic, integrative, natural or culturally specific types of healing practices:

    a. Education: Government-mandated educational standards for the multidisciplinary and the broad domain of healing arts can be misleading and unrealistic and can decrease consumer access to practitioners that do not abide by governments' mandates. Attempts to regulate may involve setting arbitrary numbers of classroom

hours at selected types of educational institutions with the receipt of conventional types of degrees, but many forms of natural healing cannot be confined to traditional learning environments or classroom or textbook training. Practitioner effectiveness may depend on inherent giftedness in the healing art. Skills may be acquired by mentoring with an individual, self-study, or other unconventional methods. Attempts by the government to quantify effective preparation needed for a particular healing art may restrict the pool of practitioners and may only serve to eliminate some of the most effective healers. Government mandates may miss some of the more intuitive or spiritual dimensions of healing skills which may not be easily defined or tested.

* Governments should allow practitioners to practice regardless of their education and training as long as they practice within reasonable conduct guidelines and provide consumers with an informed environment. This will ensure maximum consumer options.

b. Innovation: Regulation that restricts health care practice to one group and to one standard of care can decrease incentive for innovation. The healthcare field needs healthy competition in the market place and needs the freedom to expand and develop as understanding of healing grows.

* No restrictions should be put in place regarding dissemination of new ideas and information if there is no imminent risk of harm and there is an informed consumer environment.

c. Preservation of Knowledge: Health care regulation must always safeguard against the elimination of age old wisdom and knowledge of healing.

* Preservation of wisdom is accomplished only in a free and uncensored society.

d. Cooperation among Practitioners: Health care regulation that promotes turf battles instead of an interdisciplinary environment decreases the potential for cooperation and exchange of information among practitioners. Practitioners practice in fear of being charged with the practice of medicine without a license or in fear of losing their existing license for practicing outside of a defined scope.

* The least restrictive means of communication should be used to promote acknowledgment and acceptance among practitioners and promote professional coordination, cooperation and free flow of information.

e. Consumer Decision-making: Occupational regulations that limit consumer options take away important rights and motivations of consumers to decide their own healing path.

* Consumer decision making should be encouraged and regulation should support the fact that consumers that participate in their own health care decisions thrive more and have better health outcomes.

Re: Federal Regulations of Communications, Products, and Devices:

14. Federal regulation of communication, drugs and devices is not the least restrictive means of health care regulation and can negatively impact consumer options when used as the sole means of regulation. For example, the federal definition of a drug is the most restrictive type of regulation possible for health care products. Federal law defines drugs broadly to include any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease. Substances that are defined as drugs cannot be used without FDA approval and the approval process involves lengthy expensive studies economically prohibitive for the general public. This law puts an unreasonable burden of proof on the public and outlaws the use of all healing agents that have not been proven safe by the government, even when there is no documented imminent risk of harm and even when the consumer is properly informed. This drastically reduces consumer options and choice of treatments.

15. The Dietary Supplement Health and Education Act is a strong positive reform of the Federal Food, Drug, and Cosmetic Act that protects the right of access of consumers to safe dietary supplements used to promote wellness.

16. The DSHEA amended the definition of food to include dietary supplements; however, the definition of drug remains and has yet to be reformed. This reform is needed to secure the maximum number of options for all consumers.

In Summary:

I. State and federal governments must be vigilant during health care reform to preserve the balance between government regulation and an individual's right of self determination and right of choice.

II. Existing regulatory health care statutes should be reviewed and revised to acknowledge and promote the use of the broad domain of healing arts and trades in a nonexclusive manner by all consumers and by all professions both licensed and unlicensed, thus creating the widest range of choices for consumers.

III. A regulatory framework should be utilized that embodies the least restrictive means of regulation, and that provides an informed consumer environment and a system for consumer recourse in the event of a complaint. For state regulation, The Minnesota Complementary and Alternative Health Care Freedom of Access Act of 2000 can be referred to for conceptual planning. For federal legislation, bills amending the definition of the word drug can be reviewed for conceptual planning.

IV. Government should look to the future and create laws that allow for the greatest amount of innovations and that ensure freedom of consumer access to all health care options.

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Albrecht, Joan (NCCAM)

From: W. Dennis Clark [dennis.clark@asu.edu]
Sent: Tuesday, February 20, 2001 12:29 PM
To: Whccamp (NCCAM)
Subject: written statement

To the Committee:

Thank you for giving me the opportunity for providing a written statment in lieu of an oral presentation during the Public Comments period for the upcoming commission meeting. I have paste my statement into this email, below:

From: W. Dennis Clark
Dept. of Plant Biology
Arizona State University
February 20, 2001

Education causes good health. Such a bold cause-effect claim becomes almost inescapable based on surveys that correlate good knowledge with good health. Unfortunately, public knowledge about complementary and alternative medicine (CAM) derives from popular literature that is, at best, inconsistent in quality. Nevertheless, people are flocking to CAM in ever increasing numbers, buying over-the-counter and self-treatment products in spite of a basic lack of knowledge about the science and practice of alternative health care and maintenance.

Media-driven and market-driven information for the public is too often misleading, and even downright incorrect, to provide reliable CAM education. Furthermore, health-related offerings for the general student or for the public, from K-12 through post-secondary and adult education, have essentially disappeared from the curriculum. In particular, the university world has abrogated its obvious responsibility in offering general health courses, which nowadays must, based on popular demand, be developed with a strong dose of CAM education.

Clearly, any federal CAM policy must include a major thrust toward "citizen education" - that is, formal education at all school levels as well as informal education for the general public. At Arizona State University, we are working on one of the many components of such citizen education, the development of new, CAM-based offerings for "general education" science requirements at the college level. This project has potential for national impact, since universities and colleges have heretofore not responded to the current CAM trends in health care and medical practice. We expect that large numbers of students would be impacted with the wide-scale dissemination and adoption of these offerings by other institutions.

Federal CAM policy that addresses the need for citizen education must direct the creation of effective teaching materials, the dissemination of results, and the collection of convincing evaluation data on any new curriculum development. We expect that university research and development toward these goals will ultimately also encompass other levels of formal education (K-12) as well as informal education (adult or extension). Indeed, federal CAM education policy should eventually become a

- foundational model for any general federal health care policy.

Note from The Desk of
Joseph M. Kaczmarczyk, DO, MPH

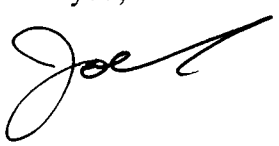
11 April 2001

Michele,

Attached is the formal response from the National Health Service Corps (NHSC) for the February WHCCAMP meeting.

Please incorporate the NHSC response in the official WHCCAMP record.

Thank you,



DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF PRIMARY HEALTH CARE

Public Health Service

Health Resources and
Services Administration
Bethesda MD 20814

MAR 30 2001

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on Complimentary
and Alternative Medicine Policy
6701 Rockledge Drive, Suite 1010
Bethesda, Maryland 20917-7707

Dear Dr. Groft:

This is in response to your letter of February 2 concerning the National Health Service Corps (NHSC) funding for complementary and alternative medicine (CAM) practitioners.

We are aware that in a meeting you were informed orally that there was no legislative authority for the NHSC to offer eligibility to CAM students and practitioners for the NHSC Scholarship and Loan Repayment Programs. We are aware that this interpretation may be viewed as narrow, and would like to take this opportunity to further explain our position on this matter.

Section 331 (a)(3)(D) of the Public Health Service Act defines primary health services as "... health services regarding family medicine, internal medicine, pediatrics, obstetrics and gynecology, dentistry, or mental health, that are provided by physicians or other health professionals."

As a direct response to increased demand by underserved communities for the services of mental health professionals other than psychiatrists, the NHSC expanded its recruitment efforts to include these clinicians. Throughout its history, the NHSC has assisted underserved communities to recruit and retain the clinicians they require to meet the health care needs of their populations. The NHSC remains committed to being responsive to the communities it serves across the Nation, and, to date, the NHSC has received no expression of interest by underserved communities for the services of CAM practitioners.

Another point to consider: the NHSC is required to place its clinicians in health professional shortage areas (HPSAs). There are methodologies in place to designate primary care, dental, and mental health HPSAs, but none to measure the relative shortage of CAM practitioners. As a result, if the NHSC were to consider including CAM practitioners, it would be difficult to determine the areas of need in which they might be placed.

Finally, it must be pointed out that the NHSC meets barely 11 percent of the identified need in primary care, dental, and mental health HPSAs. Moreover, under current budget constraints, the program is faced with the dilemma that increasing support in any one area (primary care, dental, or mental health) must come at the expense of having to do less in the other two. Any expansion by the NHSC into additional areas of health care would make it harder for the program to meet those needs that are already clearly identified.

In summary, given its budgetary constraints, the methodological difficulties, and, most importantly, the lack of demand for CAM services on the part of underserved communities, the NHSC does not contemplate the addition of CAM practitioners into its workforce.

We hope this more detailed explanation is helpful.

Sincerely yours,

Donald L. Weaver, M.D.

Donald L. Weaver, M.D.
Assistant Surgeon General
Director
National Health Service Corps

Testimony presented to the White House Commission on Complementary and Alternative Medicine Policy

February 23, 2001
Hubert H. Humphrey Building, Room 800

Robert Scholten, MSLIS, presenter.

Dr. Gordon, Commissioners, thank you for this opportunity to speak to you this afternoon. The concern and dedication you each bring to this commission is evident and I congratulate you.

I am a librarian by training and have been the Information Officer at the Center for Alternative Medicine Research and Education at Harvard Medical School for four years where I also coordinate four CME conferences cosponsored by Harvard, Stanford and UCSF. My remarks today concern access to information on complementary therapies by the students, conferees, researchers and clinicians with whom I work on a daily basis. Their requests are easily summarized:

- What is the aggregate of evidence for use of these therapies?
- Where can this evidence be located?
- If only anecdotal information exists, is it recorded, and how can I get ahold of it?
- If the therapy is part of an historic tradition, is it documented authoritatively?

I think it is fair to say that access to information remains one of the most critical factors that allow successful integration of complementary therapies into our healthcare institutions. While we are fortunate to possess numerous commercial and governmental databases that help information professionals provide data to our researchers, I believe the federal government can and should do more to coordinate access to important international resources on CAM practice that are not currently in the public domain.

I invite the commission to consider the creation of a Task Force charged with the creation of a Information Strategic Plan that is truly international and collaborative in nature. This task force should be equipped with a federal mandate and concomitant resources that would allow it to open negotiations with the World Health Organization, ESCOP, Ministries of Health in other countries, and other worldwide stakeholders. Its principal goals should be to ease access to existing data, coordinate the creation of new databases on a collaborative basis, and set standards for data encoding and exchange specifically in the field of CAM research.

The first priority of this task force should be to undertake an inventory and critical evaluation of the current state of information resources available to English-speaking CAM researchers today. This should include all governmental, quasi-governmental and commercial initiatives. It should specifically seek to identify existing databases that remain largely inaccessible to students and scientists for one reason or another.

Second, it should survey scientists, clinicians and informational professionals in order to determine whether or not the current resources are considered adequate or authoritative enough to allow proper prioritization of research projects and clinical recommendations.

Implementation of a strategic plan has many potential important benefits in multiple sectors.

1. By presenting this document to the public, it will serve to galvanize and coordinate the resources and individuals already focused on this work.
2. It would reduce redundancy and allow targeting of scare resources to projects that hold promise in addressing major data challenges in CAM.
3. It would allow commercial organizations develop resources that are compatible with standards adopted through international agreements.
4. It would assist in the identification of databases that should be translated into English.
5. Access to repositories of proprietary data might yield pilot data that researchers could use as a basis for R01 applications to the NIH.
6. And finally, it should authorize the creation of international pharmacopoeias and consensus statements that will facilitate the adoption of specific therapies into the medical mainstream.

MEDLINE, one of the world's most valuable medical resources, is now available essentially free to the world precisely because it is government supported. There is adequate precedent that the government is qualified to take leadership in this domain. I thank you for your consideration.

Robert Scholten, MSLIS
Information Officer
Division for Research and Education in Complementary and Integrative Medical Therapies, Harvard Medical School

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Attachments:

1. Recommended resource list
2. Examples of resources not in public domain

INFORMATION RESOURCES ON COMPLEMENTARY AND ALTERNATIVE MEDICINE

Compiled at the Center for Alternative Medicine Research and Education
Harvard Medical School
Updated: January 2001

I. Peer-Reviewed Journals

- *Complementary Therapies in Medicine*
  Andrew Vickers, PhD., USA Editor, Churchill Livingstone, New York, $230 quarterly
  Phone: 877-784-6463; web site: www.wbsaunders.com/periodicals/journals/journals.htm
  - Peer-reviewed, MEDLINE

- *Alternative and Complementary Therapies*
  Anne Hendren Coulter, PhD., Editor, Mary Ann Liebert, Inc., Larchmont, NY, $140 bimonthly
  Phone: 914-834-3100 or 1-800-M-LIEBERT; fax: 914-834-1388; web site: www.liebertonline.com
  - Peer-reviewed, MEDLINE

- *Alternative Medicine Review*
  Alan Miller, ND, Kathleen Head, ND, Editors, Thorne Research, Inc., Dover, ID, $85 bimonthly
  Phone: 208-263-1337; fax: 208-265-2488; e-mail: altmedrev@thorne.com; web site: www.thorne.com/altmedrev/index.html
  - Peer-reviewed

- *Alternative Therapies in Health and Medicine*
  Larry Dossey, MD, Executive Editor, Innovision Communications, Aliso Viejo, CA
  $59 bimonthly
  Phone: 800-899-1712; fax: 714-362-2020, e-mail: alttherapy@aol.com; web site: www.alternative-therapies.com
  - Peer-reviewed, MEDLINE

- *Journal of Alternative and Complementary Medicine*
  Jackie Wootton, Managing Editor, USA, Mary Ann Liebert, Inc., Larchmont, NY, $93 bimonthly
  Phone: 1-914-834-3100, fax: 914-824-3688; e-mail: info@liebertpub.com; web site: www.liebertpub.com
  - Peer-reviewed, MEDLINE

II. Electronic Databases (in order by usefulness)

- Cochrane Library
  Web site: www.update-software.com/ccweb/cochrane/revabstr/ccabout.htm
  - The Cochrane Library is an electronic publication designed to supply high quality evidence to inform people providing and receiving care, and those responsible for research, teaching, funding and administration at all levels. It is published quarterly on CD-ROM and the Internet, and is distributed on a subscription basis. The Abstracts of Cochrane Reviews are available without charge and can be browsed or searched. (Annual subscription ~$220.)

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- CAMPAIN Database
  Complementary Medicine Program, University of Maryland Medical School, Publisher
  www.compmed.ummc.umaryland.edu/ris/risweb.isa
  - A bibliography of references focusing on musculo-skeletal diseases and CAM maintained by one of the oldest NCCAM-funded Centers of Excellence and Cochrane Collaborating Center for CAM. (Free.)

- Natural Medicines Comprehensive Database
  Published by *Pharmacist's Letter*. 209-472-2244
  www.naturaldatabase.com
  - Over 1,000 referenced monographs on herbal and dietary supplements available on the web or in hard cover. Paper version includes good cross-referenced index. Also includes product database. Many references are to secondary literature, however. ($92)

- Massage Database
  Tiffany Fields, Publisher
  Web site: http://gehon.ir.miami.edu/touch-research/massref.html
  - One of the leading researchers of therapeutic massage has built a database of clinical studies on the use of massage in disease prevention available through University of Miami. (Free.)

- ALTMEDEX
  Micromedex, Publisher
  Phone: 800-525-9083; www.micromedex.com
  - Well-known publishers of PoisIndex and other databases used in critical care facilities. 140 herbal monographs created in-house and access to Royal Pharmaceutical Society monographs as well. Currently developing additional monographs for other CAM modalities. (Single user licenses may not be available.)

- AMED
  The British Library, Publisher
  CD-ROM subscription from Silverplatter: 781-769-2599, 800-343-0064
  www.silverplatter.com/catalog/amed.htm
  - Citations and abstracts to 96,000+ articles indexed from 400 international journals (many of which are not indexed by MEDLINE or EMBASE). Indexing started in 1985. Available on many online services as well. (Single user license ~$1,000.)

- Alt.Healthwatch
  Cyberstax, Publisher, CD-ROM and web-based subscriptions.
  Phone: 800-524-7922; web site: www.epnet.com/database.html#awh
  - First U.S. full-text database developed on alternative medicine for the consumer market available through many online services. Contains about 40% peer-reviewed articles with full information on each journal including names of editors. Well-designed, easy-to-use format.

- British Medical Association Collected Resources
  www.bmj.com/cgi/collection/complementary_medicine
  - A compilation of articles that have appeared in various BMA journals in recent years.

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- IBIS (Interactive Body-Mind Information System)
  Integrative Arts, Inc., Publisher; CD-ROM subscription.
  Phone: 877-526-IBIS; fax: 503-641-6541
  web site: www.Integrative-Medicine.com
  - A clinical database referencing 282 common medical conditions with corresponding therapeutic options from more than twelve systems of conventional medicine, alternative therapies and integrative healthcare. Unique reference tool whether or not one agrees with the principals underlying the therapeutic traditions. Editor is licensed chiropractor, acupuncturist and naturopath. ($99)

- Bonnie Snow List of Important Databases
  Web site: www.onlineinc.com/database/DB1998/snow8.html

- MANTIS (Manual, Alternative and Natural Therapy)
  Ron Rupert, Publisher
  Web site: www.healthindex.com/MANTIS.asp
  - Citations from 1,000+ journals. Particular emphasis is given to osteopathy and chiropractic, other alternative and complementary medical topics and treatments are also covered. (Single user and institution-based licenses available.)

III. Other Periodicals

- *FACT: Focus on Alternative and Complementary Therapies*
  Edzard Ernst, MD, Editor, Pharmaceutical Press, Wallingford, Oxon, $108 quarterly
  Phone: 44-1491-829-272; fax: 44-1491-829-292; web site: www.pharmpress.com
  - Abstracts, systematic reviews

- *The Integrator*
  John Weeks, Editor and Publisher, Integrative Medicine Communications; $199 (12 issues)
  Phone: 877-426-6633; fax: 617-641-2301; e-mail: integrator@onemedicine.com, web site: **www.onemedicine.com**
  - Currently the only serial focusing exclusively on the business, reimbursement, and credentialing aspects of integrative medicine. E-mail alert service available at extra charge.

- *Nutrition Business Journal*
  Tom Aartz, Editor, Environmental Business International, $795 (50 issues), Archives available.
  Phone: 619-295-7685 ext. 10; fax: 619-295-5743; e-mail: ebi@ebiusa.com web site: www.nutritionbusiness.com
  - Strategic information for decision making in the nutrition and herbal industry.

- *Natural Health Line (electronic)*
  www.naturalhealthvillage.com
  - Site is especially useful for perspectives on consumer demand, policy and legislation. One of the best services it offers is this semi-monthly email-based newsletter and alert service which is available through free subscription.

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- *Alternative Medicine Alert*
  American Health Consultants, Publisher, $229 monthly
  Phone: 800-688-2421
  www.ahcpub.com/ahc_root_html/products/newsletters/ama.html
  - Newsletter

- *Acupuncture and Oriental Medicine Accreditation Commission (ACAOM)*
  Silver Spring, MD 301-608-9680, Free
  - Newsletter

IV. Selected Reference Books

- *Alternative Medicine: An Objective Assessment,* edited by Phil B. Fontanarosa, Chicago: American Medical Association, 2000. $75 (A compilation of articles that appeared in the November 1998 AMA journals series focusing on alternative medicine.)

- *Essentials of Complementary and Alternative Medicine*, edited by Wayne Jonas and Jeffrey Levin. Philadelphia: Lippincott Williams & Wilkins, 1999. $40

- *Complementary/Alternative Medicine: An Evidence-Based Approach,* edited by John Spencer and Joseph Jacobs, Mosby, 1999. $42

- *Evaluating Alternative Cancer Therapies: A Guide to the Science and Politics of An Emerging Medical Field,* edited by David J. Hess, New Brunswick: Rutgers University Press, 1999. $35

- *Principals and Practice of Phytotherapy: Modern Herbal Medicine*, by Simon Mills, Edinburgh: Churchill Livingstone, 2000. $72

- *The Web That Has No Weaver* by Ted Kaptchuk, Lincolnwood, IL: Contemporary Books, 2000. $15

- *Complementary and Alternative Medicine: Legal Boundaries and Regulatory Perspectives,* by Michael H. Cohen, Baltimore: Johns Hopkins University Press, 1998. $17

- *Beyond Complementary Medicine: Legal and Ethical Perspectives on Health Care and Human Evolution,* by Michael H. Cohen, Ann Arbor: University of Michigan Press, 2000. $40

- *Complementary and Alternative Medicine: A Research-based Approach,* by Lyn Freeman and G. Frank Lawlis, St Louis: Mosby, 2001. $49

- *The Arthritis Foundation's Guide to Alternative Therapies*, by Judith Horstman and William J. Arnold. Marietta (GA): Longstreet Press, 1999 $20

- *Food, Nutrition and the Prevention of Cancer: A Global Perspective,* by the American Institute for Cancer Research (AICR) & World Cancer Research Foundation (WCRF), Washington, D.C.: AICR & WCRF, 1997.

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- *Cancer & Natural Medicine: A Textbook of Basic Science and Clinical Research,* by John Boik, Princeton, Minnesota: Oregon Medical Press, 1995. $22.50

- *Evaluating Alternative Cancer Therapies: A Guide to the Science and Politics of An Emerging Medical Field,* edited by David J. Hess, New Brunswick: Rutgers University Press, 1999. $35

- *Foundations of Nutritional Medicine: A Sourcebook of Clinical Research,* by Melvyn R. Werbach, M.D., Tarzana, CA: Third Line Press, Inc., 1997. $50

- *Choices in Healing: Integrating the Best of Conventional and Complementary Approaches to Cancer,* by Michael Lerner, Cambridge, MA: MIT Press, 1994 $15

V. Selected Websites

- National Center for Complementary and Alternative Medicine, NIH
  Website which includes links to academic research centers, the Information Clearinghouse, and other useful information.
  http://altmed.od.nih.gov/nccam/

- ODS (Office of Dietary Supplements) at NIH
  Website offers access to a number of periodicals published by ODS and its database of citations of interest to the field.
  http://dietary-supplements.info.nih.gov/

- McMaster Universities' Alternative Medicine Meta-Index
  Very comprehensive collection of web-based health care information on alternative medicine.
  www-hsl.mcmaster.ca/tomflem/altmed.html

- DHHS HealthFinder
  This search engine and database of web-based resources is maintained by a special branch of the Department of Health and Human Services. It is targeted at a finite number of websites that undergo a stringent review process before they are catalogued into the system. Search engine currently indexes approximately 300 sites for alternative medicine
  www.healthfinder.gov

Please mail all corrections or additions to this list to camr@caregroup.harvard.edu, Attn: R. Scholten.

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Worldwide Resources on Complementary and Alternative Medical Therapies

Annotated list of examples of resources with access problems

CISCOM
- database produced by the Foundation for Integrative Medicine, UK
- serious duplication of effort, in competition with NCCAM's database and AMED of the British Library Association.
- very small budget, and no public interface available.
- no harmonized thesaurus or list of journals covered available.

WHO Adverse Effects of Herbal Drugs Database
- database produced by Drug Monitoring Centre, Upsalla, Sweden
- over 7,000 reports collected from federal centers in all participating countries coded with harmonized, international adverse effects coding system.
- no public access available, no budget for ongoing collection of reports.

WHO Therapeutic Coding System for Herbal Medicines (ATC)
- database produced by Drug Monitoring Centre, Upsalla, Sweden
- new coding system under development by team for therapeutic indices of all herbs.
- budget very small and attempts at international collaboration uncoordinated.

Aids Care Project
- data collected in Boston, MA clinics over the last four years.
- over 6,000 acupuncture procedures performed on a quasi-primary care basis on a cohort of HIV+ patients.
- No budget for systematic evaluation or research of outcomes.

Approved Japanese Kampo Medicines
- approximately 180 herbal combination products approved and monitored by Japanese Ministry of Health.
- no comprehensive list of research and/or outcome measures available in English.

NAPRAlert
- sophisticated database of 200,000 citations to botanical literature indexed by University of Illinois, Chicago.
- Searching the database extremely expensive and very difficult.
- Extensive thesaurus developed by staff has potential to be worldwide standard but at the moment is not even accessible online.
- Citations carry no abstracts.
- As recent as 1999, continued funding was in serious doubt.

Neil Sampson Remarks
White House Commission on Complementary and Alternative Medicine Policy
"Training, Education, Credentialing, and Licensing of CAM Practice"
February 22, 2000
Hubert H. Humphrey Building, Washington, D.C

Good morning. I'm honored to have this opportunity to speak before such a distinguished commission on the role of HRSA's Bureau of Health Professions in preparing tomorrow's health providers.

As you are well aware, the demographics of this country are changing. In fact, within the next two years, the Hispanic population in America is expected to surpass African Americans to become the most populous minority group. And by 2050, less than 50 years from now, the total number of all minority groups combined is expected to make up approximately half of the total U.S. population.

With these changing demographics comes changing reliance, involvement, understanding and acceptance of "conventional" health care practice as we know it.

More and more Americans of all cultures are taking an active role in meeting their own health care needs. As a result, more and more are turning to and relying on complementary and alternative therapies.

This increase among consumers is spurring change in health education curriculum as schools strive to prepare their students. In fact, we've been

told that already approximately half of the medical schools in this country have courses or other educational activities on CAM.

However, we believe the inclusion or expansion of CAM should not be limited to education for physicians alone. Rather, CAM therapies should be incorporated into the curriculum for all health professions disciplines.

BHPr's Current Involvement in CAM

The Bureau of Health Professions' involvement in training and education programs on CAM, at this point, is very limited.

The Bureau's Division of Nursing currently funds three graduate programs that include content on complementary and alternative therapies. And BHPr funds the Chiropractic Demonstration Project Grants Program, which supports research projects where chiropractors and physicians collaborate to identify and provide effective treatment for spinal and lower-back conditions. Currently, research is the only activity legislatively authorized under this program.

Unfortunately, that is the extent of the Bureau's involvement in CAM. I wish I could share good news on financial assistance available to CAM students.

The reasons for this are simple. All of the Bureau's Title VII and VIII training and education programs are established through specific legislation in the Public Health Service Act. These programs are directed toward

specific health disciplines and, as a result, we have very little leeway in how we allocate funds.

In fiscal year 2000, BHPr awarded 1,741 new and continuation grants. And this year, we will invest some $353 million in training and education programs directed toward physicians, nurses, dentists, public health professionals and allied health providers.

Where Do We Go?

Should BHPr be involved in training and education programs for CAM practitioners? I believe that we should be—for a number of reasons.

First and foremost, to keep pace with changes in the Nation's health care system, it's imperative that providers are prepared to meet the challenges of the future.

The Federal government, through BHPr, can play a leadership role by convening medical education leadership conferences, encouraging the development of standards of education, and positioning Titles VII and VIII as vehicles for faculty and curriculum development initiatives.

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

And while knowledge about CAM is still developing and evolving, the Bureau believes that there should be a minimum level of postgraduate education required for non-allopathic or non-osteopathic *physicians*, which leads to state certification or license. This would allow for some level of standardization.

For other health professions disciplines, we believe that all educational and training programs should address a set of core requirements, which are aligned with program accreditation, other recognition, and licensing requirements.

The licensure of all practitioners—whether they provide complementary and alternative therapy or conventional health care—is absolutely necessary as a safeguard to protect the public.

To illustrate, I'm reminded of an article I read from Sunday's [February 18, 2001] San Francisco Chronicle—that's right, just four days ago. This article reported on Stockton, Calif., resident Gerald Barnes, a physician who for 20 years worked at community clinics treating poor patients, flew volunteer medical missions to Mexico, and worked as head doctor in a Los Angeles clinic.

The problem is: Barnes wasn't a real doctor. Over the years, he falsified his credentials.

While this story doesn't directly address CAM practitioners, I believe it does point out the need for strong state licensing and certification requirements to protect the American public.

And finally, the structure of the workforce—namely scopes of practice, credentialing, roles, numbers and mix—has been and continues to be a matter of debate. Emerging therapies and professions are part of this debate. Such changes can be influenced, but probably not imposed, from the federal level.

However, it is important and relevant to periodically monitor the workforce to determine shifts and trends, which could impact access to practitioners, health care, cost and quality. Such efforts help identify problems and allow for health policy makers, state and national leaders, health professionals, service providers and payers and consumers to determine issues, discuss strategies and consider appropriate actions.

BHPr, through its National Center for Health Workforce Information and Analysis, has held and could hold in the future meetings on health workforce issues. Through such research meetings we can better assess the impact of workforce on health care delivery and determine where we are and where we need to go.

Unfortunately, we know that once we get beyond physicians, nurses, dentists and pharmacists, our data is very limited. This is where professional associations, schools, and licensing bodies can help. These groups can help collect the data we need to assess this emerging CAM workforce.

The Bureau's role in health professions training and education is assuring the right providers with the right skills are available to provide health care in the right places.

We recognize the growing interest in complementary and alternative therapies and believe that tomorrow's health care providers must be prepared to meet the health needs of their patients.

We are ready to meet the challenges of the future.

Thank you.

-Technique
The Schenk Human Energetic Institute LLC
220 E. 26th St. Suite 1B, New York NY 10010
Tel (212) 9517107, Fax (212) 6845692
email cwalkerrn@aol.com

February 23, 2001 Testimony for The White House Commission on Complementary and Alternative Medicine

Educational Training Concerning Side Effects and Adverse Reactions of Complementary and Alternative Medicine

Testimony given by Christina Walker RNMA Chief Operation Officer for The Schenk Human Energetic Institute. Christine Schenk Founder. The Schenk Human Energetic Institute offers a training program in the anatomy and physiology of the energy body system and side effects of alternative therapies. This is taught by the CHRIS® Technique which is a specially developed technique based on an inter-system approach that allows individuals to filter out any and all types of energy body system interventions from everyday events and psycho-social care methods. This technique enables individuals to select more easily from among the therapeutic support options for meeting energy body needs.

Alternative Medicine modalities are medication to the human energy body system and with any medication we have side effects and adverse reactions. The energy body system is as complex network system as complex as the anatomy and physiology of the physical body. This entire network needs to be considered when offering CAM therapies

Christine Schenk teaches this anatomy and physiology of the energy body system and I have included some excerpts from her book and her training program. Christine teaches not only the energy body anatomy and physiology but also how to become aware that this entire body is a living being. That we exist as energy body. Through experiential exercises everyone is given the opportunity to feel the energy body system anatomy within themselves and others. This method of teaching is reproducible to anyone you do not need a special gift. It is no different than a doctor saying here is the liver and we all feel the liver.

According to Christine Schenk the energy body consists of centers, disks, charkas, layers meridians, and nadis. Therefore the appearance and health of a chakra is mainly dependant on the supply of energy via the organs "From this perspective it is not sensible to balance a chakra by means of energy work as long as the center belonging to that chakra is destabilized". So the question is what is happening to the energy center when hands on healers are balancing charkas? Acupuncture works on one part of the system -meridians, but how does this technique affect the entire energy body network system?

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"Just as the physical body maintains its balance through the skeleton system, the energy body is composed of a large number of disks. This means that experiences and memories can be sorted according to subjects and stored in zones of the energy body. For instance plans during life and access to family history. Adverse reaction to therapies that could affect this area would appear as behavioral changes in job and family. As psychiatrist and psychotherapists we must be aware of the possibility of our client attending a weekend course in consciousness and how it can affect the disks of the energy system.

"The energy body consists of several layers which coordinate to varying levels of perception. As for example we search on the radio for a certain radio station frequency band. The energy body organism does a similar process it processes different perception and sometimes it may get lost or stuck. Again we can see how a person who may have problems in the area of the layers would end up with the psychotherapist. There is one CAM treatment that we should keep in mind that will also affect the layers of the energy body system and that is homeopathy.

In Europe Christine Schenk has seen the adverse effects, which are often concealed behind physical diseases such as sleeping disorders, constant fatigue, backache or constipation. Additional symptoms that have been reported are dizzy spells, hot flushes, shaking chills, circulatory problems, depression, and changes in eating habits. These symptoms hide behind know diseases such as depression, lack of coordination, etc. belong to a new generation of diseases belonging all to side effects of the pioneering energy medicine. Since a lot of the symptoms show up in the physical body or mental disorders this will bring the patient to a health care provider looking for an answer. This is the education that is needed for practitioners to distinguish a physical aliment from an energetic side effect of CAM therapies. CAM therapies have a double function. They have access for real physical body problems and can heal them but to energy body related symptoms as well. But energy body symptoms also present themselves as physical body problems. How do we distinguish what is what?

My own personal experience as an alternative medicine practitioner and a consumer of alternative medicine modalities I have experienced side effects and adverse reactions on both sides. This research had lead me to find Christine Schenk and her work with the energy body system. It is from her that I learned I was dealing with an occupational disease burn out syndrome. Such diseases develop primarily from the handling or application of energetic medicine. The disease arise in those situations where one works with energy, regardless of

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whether energy is balanced, revitalized, recharged, or added, whether it is made to flow, whether blocks are removed, entire energy systems are harmonized or energy is stored in the form of information, recalled, altered, anchored or erased. Conversations with acupuncturist, physicians, psychotherapists, nurses or body workers revealed they were unaware of potential side effects ensuing from inappropriate or excessive applications. I thought all these side effects were just from formerly touching my clients so I studied spiritual psychology and still I would experience the same side effects. I experienced a huge awareness that energy is involved with talking, touching and distant healing. This is powerful and how do we work in such a field as to do no harm.

The Commission should offer guidelines for the public in what to look for when considering CAM therapies given by a practitioner. This would begin with

Distinguish which body physical or energy needs treatment

Distinguish your own personal energetic or physical diseases before seeing a practiitioner

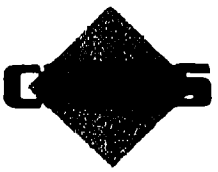
Consider if you have energy body reactions by taking too much (or oppositional) energetic treatments

Inform your practiitioner about any energy related medication or therapy

Thank-you for this opportunity to testify before you today

Best Regards,

Christina Walker



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FAX TRANSMISSION

To: The White House Commission on CAM Policy

Fax #:

From: Christina Walker

Date: February 15, 2001

Re: Testimony

6 *page(s) including this one. Please inform us if you do not receive all pages.*

☞ **Enclosed is my registration form and my testimony**

White House Commission on Complementary and Alternative Medicine Policy

Meetings

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Registration Form

February 22, 2001 – 8:15 am – 6:00 pm
February 23, 2001 – 8:15 am – 6:00 pm
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC

Last/Family Name*	Walker
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* Indicates Required Field

Anyone wishing to present oral comment must register by **February 19, 2001**

I wish to: (•) provide oral comment on February 23, 2001

( ) Observe (no oral statement)

NOTE: Oral Comments will only be heard the second day.

NOTE: There is a 5 minute limit for all oral comments - 3 minutes for testimony and 2 minutes for questions

My oral comments will focus on:(check any that apply)

☐ **1. Coordinated Research and Development to Increase Knowledge of Complementary Medicine Practices and Interventions.**

- What can be done to expand the current research environment so that practices and lie outside conventional science are adequately and appropriately addressed?
- What types of incentives are needed to stimulate the research of CAM practices and the public and private sectors?
- How can we move effectively integrate the CAM and conventional research commun and coordinate research?

☐ **2. Guidance for Access to, Delivery of, and Reimbursement for Complementary and A Medicine Practices and Interventions.**

- Do you have ready access to CAM practices and interventions?
- How can access to safe and effective CAM practices and interventions be improved?
- What types of CAM practices and interventions should be reimbursable through fede other health care coverage systems?

☑ **3. Training, Education, Certification, Licensure, and Accountability of Health Care Pra Complementary and Alternative Medicine.**

- How can uniform standards of education, training, licensure and certification be appli practioners?
- What training and eductaion should be required of all health care providers to assure and effective CAM practices and interventions?
- Are performance standards or practice guidelines needed to ensure the public will ha full range of safe and effective CAM practices and interventions?

☐ **4. Delivery of Reliable and Useful Information on Complementary and Alternative Mec Care Professionals and the Public.**

- How can useful, reliable, and updated information about CAM practices and interven more accessible? How would you like to receive this information?
- As a consumer, what kinds of information about CAM practices and interventions are important to you?
- As a health care provider, what kinds of information about CAM practices and interve needed and important to you?

Please provide a written summary of your 3 minute oral statement (500 characters or

Testimony will be faxed

Special Assistance Requirements:

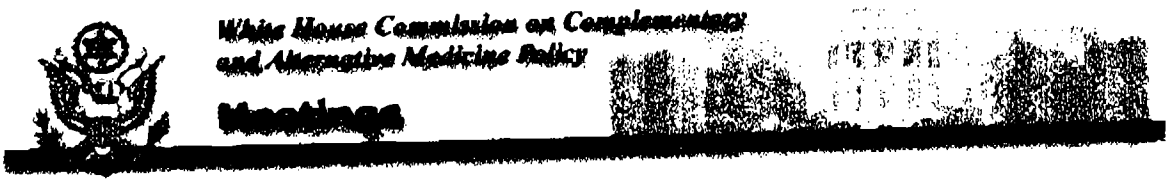
☐ Sign Language Interpretation

☐ Wheelchair Access

☐ Other

[redacted] [redacted]

Note: If you have problems submitting this form, please call 1-866-373-1124, or you can print this form, fill 301-480-1891.



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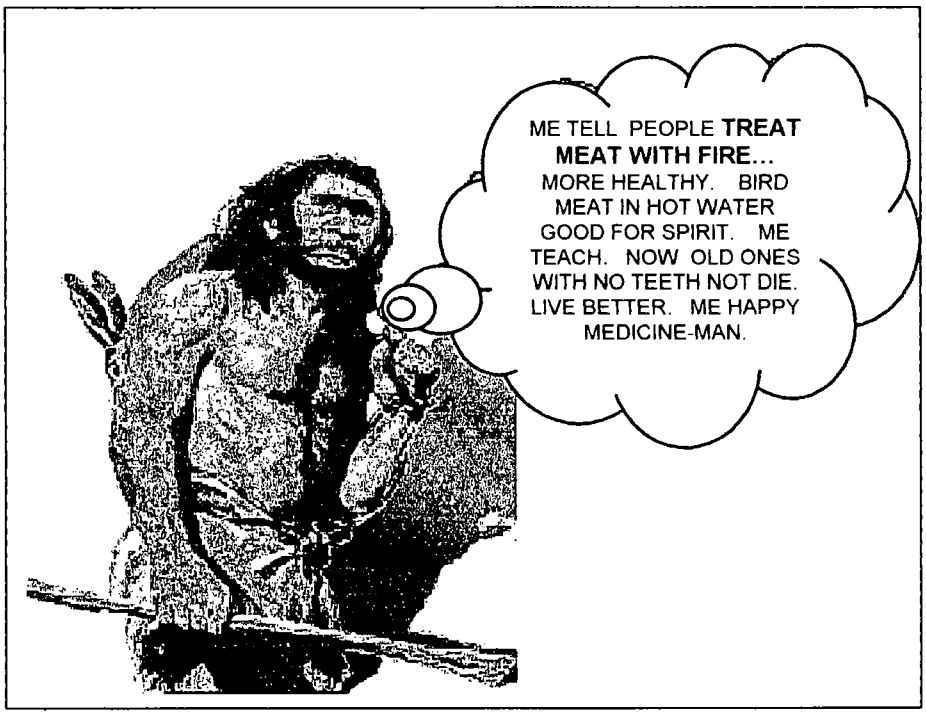
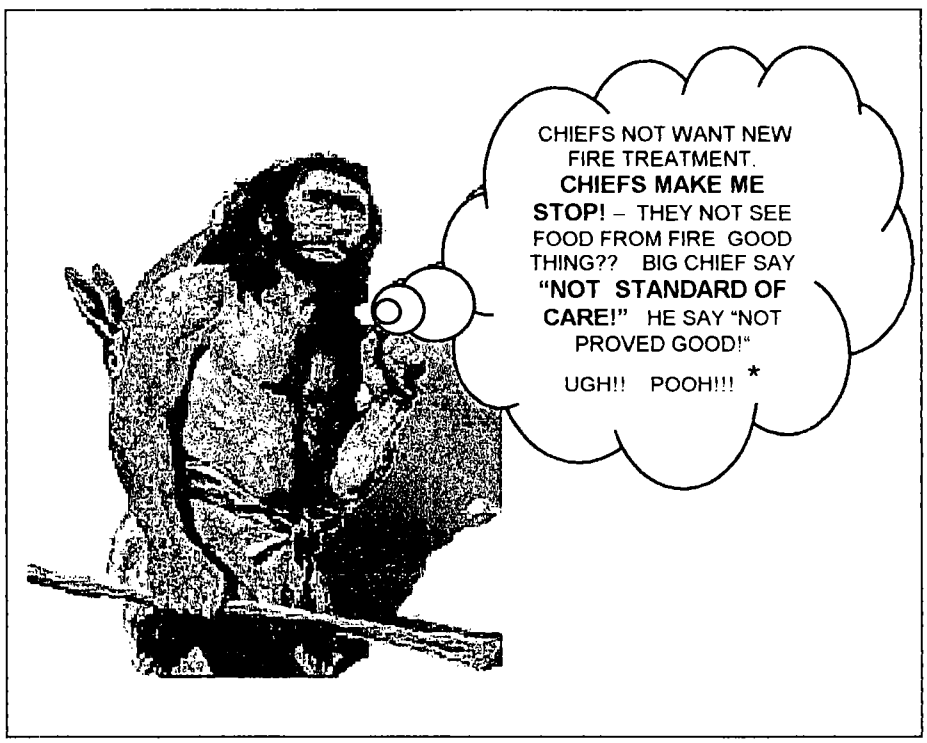
THE FIRST DOCTOR OF ALTERNATIVE MEDICINE



And in Trouble With His Medical Board . . .



* "Ugh, Pooh" - We were unable to translate these clinical terms