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WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

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Meeting on Training, Education, Credentialing and Licensing of CAM Practice

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Volume I

+ + +

Thursday, February 22, 2001

8:15 a.m.

Hubert H. Humphrey Building, Room 800
200 Independence Avenue, S.W.
Washington, D.C.

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C O N T E N T S

CONTENTS (continued)

P R O C E E D I N G S

[8:20 a.m.]

DR. GROFT: Good morning, everyone. If you take your seats, we will get started. We're a little bit late. With the threat of the snowstorm coming this afternoon, we want to maintain some degree of sanity here in the Washington area, because if you have been here in the midst of the snowstorm, you know what it's like.

The Commission members are here and they will be sequestered for the next two days, regardless of the outcome of the weather. So we're happy they are here, and it will be a very, very busy meeting.

I am Steve Groft, and I am serving as the Executive Director of the Commission. I will turn it over to Jim Gordon here in just a minute. I would like to thank everyone for coming and listening. For those of you who we have asked to send information, I think our response to your response has been overwhelming. We have been extremely pleased at the thought that has gone into many of the responses that we have heard from the public.

I think you will see later on in the breakout sessions, and we will talk about that a little bit later

as well, that it has been tremendous. There has been a lot of thought, and you can see that people have been thinking about some issues for a number of years. I think the Commission now, with us being in operation and getting ready to prepare the report, you are going to see tremendous changes coming within the next two to three years, with more and more emphasis coming on CAM therapies and products. It is a very exciting time.

Just a couple of notes. This will have a little bit of a different format. Until today, the Commission was pretty much in a listening, and in an information-gathering mode. We will continue to do those two functions, but we also want to start to develop recommendations.

I guess I have been hearing that the Commission has already taken a position on certain issues and we're looking at this, we're thinking this. I can assure you, we have really not taken any position and developed any recommendations. This will start today, and at future meetings, you will start to hear more and more things. We really won't come up with definitive recommendations even today or at the March meeting. You will see them as

we get ready for the interim report in July.

So please stay with us. We do welcome your input and advice. We read everything that comes in, and so it's quite a bit.

I just wanted to let you know, also, there will be a Town Hall meeting in the Minneapolis-St. Paul area on March 16th. It is going to be at the University of Minnesota. There have been a number of new initiatives there that we want to go out and hear about.

We had a Planning Committee; we had a very successful meeting in Seattle, Washington, that there was a Planning Committee, and it worked out extremely well. I think those of you who traveled with us to New York for the CAM marathon, 12 hours to listen to about 136 speakers, we knew we were in New York, but we didn't know it was that big. So it was a tremendous effort, especially with Jim chairing the entire session; a tremendous turnout and tremendous responses that we heard from people.

If you have not visited our website, please do so. We've made a lot of efforts to get the agendas, the Federal Register announcements, and now the transcripts

up from the meeting. By next week, we will have all the transcripts on the Internet and our website from all the meetings, except this one.

It is changing, and the registrations are going through the website. It is more interactive, and it will become even more so in the future as we go along. So please do visit it, and we can cut down some of the costs to the offices, because as soon as have the meeting schedules, they are up there. Please look at it and follow our activities.

One last thing. This afternoon and tomorrow morning, many of you had wanted to provide some comments at the Open Public Session. Because of the time factor, we are only able to devote about an hour and a half tomorrow afternoon, and that only permitted approximately 20 people to make presentations to the Commission. So Dr. Gordon has agreed this afternoon, during the first breakout session, and then again tomorrow morning at the second breakout, Breakout Session No. 2, starting at about 8:15, we will have a small conference room that we will meet with whomever would like to come in and talk with Dr. Gordon, myself and Michele Chang, the executive

secretary.

So we want to hear from you, and if you feel that we haven't given at the Open Public Session, we will be available to talk with you at that point in time. I think it is the best we could do in the situation that we are looking at. It is going to be 634-F, and there will be some schedules. There are some schedules in the back of the room.

Also, in the breakout session, I know some of you have certain groups that you would like to hear what they said in their responses to the Commission on the issue that we are discussing today. We have them in the back of the room, so feel free to go to that conference room and area to listen to what is going on.

We are restricting public participation at that point because they are small group discussions, but they need to go through a lot of material and come up with some type of draft recommendations at that point in time, so we ask your cooperation. There will be breaks for you to talk with the Commission members and with the Chair at various points during the next two days.

DR. GORDON: Thank you, Steve.

Good morning, everybody. We are going to sit for a moment in silence and collect ourselves, and be present together in the room. So let's do that.

[Moment of silence observed.]

DR. GORDON: I want to begin now by welcoming our new commissioner. This is his first commission meeting, and that is Dr. Joe Pizzorno, who was president of Bastyr College in Seattle. Although he is retired from that, he has not retired from being the leader in complementary and alternative medicine, and hoping all of us nationally move things ahead.

So, Joe, welcome. Do you want to say a couple of words to everyone?

DR. PIZZORNO: Well actually, I have been following what the Commission has been doing very carefully for the last almost a year, and I want to congratulate you all for the work that you are doing.

I can't tell how delighted I am to be a part of this, and hopefully will work collaboratively with you over the next year to get a report that will change health care. Thank you.

DR. GORDON: Great.

[Applause.]

DR. GORDON: Thanks so much, Joe.

Joe Fins should be here later. Bill Fair is not going to be coming today. We also have a new member of the Commission, and I think it is important that he be introduced.

So, Dean, if you would introduce the new member who is here with us.

DR. ORNISH: This is our new member. His name is Lucas Ornish. He is three months and one week old.

[Applause.]

DR. ORNISH: Thank you. If I fall asleep during the meeting, it's nothing personal, you understand. I have been up since 3:00 this morning.

DR. GORDON: Thank you. It's great to have Lucas here with us, as well as you.

It's great to be back with all of the Commissioners. One of the things that has been happening that I have been able to observe, and that we have been able to observe here in the office, very clearly, is the evolution of the Commission and the evolution of everyone's engagement of the process.

So I have been struck, both at the last full commission meeting, and also at the meeting in New York, about how well we have been working together and how committed commission members have been in a variety of ways, everything from being extremely disciplined about questions and extremely focused in questioning, to a willingness to participate and participate in helping to plan meetings.

This meeting, as the Commissioners know but perhaps people in the audience don't know, is a different format. It is a format that is specifically designed for this topic of education, professional education, and credentialing. It is one that has engaged every commission member in small group discussion and planning.

As Steve mentioned, there will be small groups, starting this afternoon, which will address all of the issues on the agenda from different professional perspectives. We are very excited about this format, and in order to make it happen, the Commissioners have had to do a great deal of work. You may see on some of the desks, there are two large books of information that people have been pouring over.

Also, the staff has done an extraordinary job in reaching out to about 150 organizations which have submitted. We have gotten an overwhelmingly positive response in terms of a variety of different organizations.

You will see and hear about some of them in the small group meetings, as well in the large group, that have sent us their thoughts, their responses to, I think, very well-crafted questions about what their thoughts are about CAM education from their various perspectives, from perspectives of professionals, conventional professionals, CAM professionals, consumers' groups, licensing boards, et cetera, et cetera, et cetera. So this has been an extraordinary effort, and I am very much looking forward to the day.

As Steve mentioned, there will be a time this afternoon and tomorrow morning for any of you who would like to talk with me, or with Steve, or Michele in Room 634-F. We will be there. We will be very happy to hear from you. We encourage you to go to the small groups. I think I said once before, the operation of the Commission is not only transparent, it's translucent, and we welcome

you to see us working together, beginning to craft some of the recommendations.

One of the things I want to echo that Steve said that I think is important, and emphasize, is, there will be many recommendations. This is for Commissioners as well. We want you to make many recommendations from your small group meetings, and we are going to put them all up. We are not going to decide today, and I will probably say this this afternoon, which ones, or the wording. What we want to do is get the best thoughts of the small groups, and then we will put them together.

So without further ado, let's begin with the first panel.

MS. CHANG: Would the following speakers please come up to the tables: Dr. Louis Orzack; Jennifer Engstrom; Deborah Danoff; Peter Scoles.

If you have your name plates in your packages, if you could put them up in front of you so the Commissioners know who is speaking. Thank you.

Plenary Session I: CAM Education and Training

DR. GORDON: Good morning, and thank you all for coming. We will begin with Dr. Louis Orzack.

DR. ORZACK: My name is Louis Orzack. I am a professor at Rutgers University. The last 25 or 30 years, I have been doing academic research on the development of professions, both in the United States and in Europe.

Thank you very much for your invitation. The challenge you face and I face is enormous. I want to make several points concerning elements of profession, what they are. I then plan to summarize how changes in and of these professions and their services occur and do not occur. Then, to make this clear, I will discuss how complementary and alternative medicine can influence medical practice and medical education.

I will use a couple of examples of significant change in two non-CAM fields. One was far outside the mainstream of health care, the second has recently a dramatic change in educational standards for entry to practice.

Finally, I will offer some suggestions for the Commissioners to consider in order that they can meet their responsibilities. These will focus on the process of educational change for CAMs.

In my written document I present a roster of elements that characterize professions. This is not just an academic exercise. It is what we all mean when we refer to the term "profession." I cannot define them or elaborate them in the limited time I have, but I want to point out some truisms. The first, is that professions are complex. The second, is that change in any one or more of the elements is likely to touch off changes elsewhere in the system. Whether we want to discuss established professions or emerging professions, all of these elements must be affected.

All professions comprise a complex of those features. The infusions of resources that sustain, allow expansion, or curtail the experience of professions come from exchanges with the larger society. Professions flourish or disappear, depending on the stability, the increases or the decreases of those infusions. Compare health care in the modernized world with that in regions where doctors without frontiers choose to work.

I use that scheme in research about professions and professional services in order to take a look at them in a large framework. Let me briefly enumerate what they

are without defining them. I just don't have time to do that.

First, cultural and ideological mandates; second, the services and the responsibilities they offer that are accepted in different ways in society, the scopes of practice, the scopes of service, the scopes of responsibilities. There are differences. Third, public expectations in consumer issues; (4) practice standards; (5) educational systems; (6) legitimacy and legal standing; (7) regulatory systems, including licensing; (8) qualification mechanisms; (9) associations and peer interactions which provide benefits, and also impose controls; (10) association and government exchanges; (11) ethics, discipline and sanctions; (12) scientific research and technological applications; (13) boundary interactions among specialties; (14) practice patterns, such as whether people function in an independent way or in organizational settings, or both; (15) income sources, whether fees, salaries, or third party; (16) socialization and recruitment; and finally, (17) the careers, the trajectories of careers.

All of us must continue to be aware of the

complexities of professions. Emerging now or previously emerged. This provides a basis for understanding professions, a reference guide. None of the entire series of elements exists by itself. They are interrelated. Professions comprise all of these, and these elements are intertwined and interconnected.

How do they change? Well, let me give you some examples. I will provide some examples, certainly not an exhaustive list, of external sources of change. Certainly, if public confidence of health services, or in the services of particular kinds of practitioners, deteriorates, a profound crisis may occur. Internal sources of change may induce dramatic shifts in the stability of elements of professions. Changes in public perceptions of provision of health care, the quality of health care, provided by medical practitioners, may, over time, take several forms.

Medical education's adaptation to these changes may be hastened through several avenues, among which I identify a few: (1) when entering medical students introduce messages calling for a change; (2) patient's and consumer's orientations to CAM practitioners and

reliance on CAM-initiated or CAM-informed sources of information; (3) insurance carriers, state workmen's compensation systems, Medicare and Medicaid programs, and regulatory and licensing boards develop more accepting approaches to CAM services.

Changes in compensation levels, restrictions on practitioners choices, pushing our medications upon physicians by pharmaceutical reps are illustrations, possibly, of counter trends.

Ethical shortfalls or provision of services sought by patients may in fact open up opportunities for change in practitioner-patient relations. When we hear of examples of abuse, mistakes, exploitation, boundary-crossing, or neglect, the reaction to that may allow for opportunities for alteration of practices.

Determination of the validity of CAM contributions and interventions is an essential key, it seems to me, of their acceptance within health services by medicine, their incorporation within medical practice, and their inclusion within education, both in medical disciplines and in continuing education programs for those already in practice.

Practitioners in complementary and alternative medicine can increasingly become primary providers within health care services, provided that medical practitioners gain an improved knowledge of the competencies of CAM providers and reciprocally refer patients.

To illustrate some of the drastic-change opportunities that have occurred, changes that have occurred, in two health-service providing professions, I want to use as examples, as I mentioned, two non-CAM fields. They are optometry and audiology.

About 1900, optometry boasted that it was a drugless profession. In all states, optometrists are now legally able to use topical anesthetics and therapeutic agents, employ complex instrumentation in examining eyes, and provide a significant range of vision-care services. The formal education base of schools and colleges provide the O.D. degree, the Doctor of Optometry degree. Accreditation of the schools and colleges requires adherence to develop standards. A national examination tests graduates, while licensing boards in every state relies on its use. Further clinical residency slots in health care settings have been established for

optometrists. Reciprocal referral exchanges with public health practitioners, internists, pediatricians, and other primary care providers are increasingly common. Although, I understand not so with ophthalmologists. This is still not common with that field.

As a leader in that field put it recently, "The scope-of-practice responsibility advanced when leaders in education and in associations in the field chose to move ahead." "The result claimed," he stated, "is that the practicing O.D. has become part of the mainstream of health care activities."

Audiology is the second field I am using as an example. It's on the verge of major change. Last year, an out-of-court settlement in a U.S. Federal Court provided for a landmark shift in educational practice.

DR. GORDON: Dr. Orzack, I'm sorry. We are going to have to ask you to conclude in a few seconds.

DR. ORZACK: Let me do so by making some suggestions. Change can occur, and it must be pursued as a vital objective.

CAMs can move in educational change processes based on these kinds of occurrences. They can and should

place greater emphasis on educational standards located in diverse regions and states. They should strive to advance common educational standards. They should strengthen efforts to encourage consumers of its services to seek opportunities to support inclusion in health services.

They should move toward still greater public support by encouraging and generating greater public attention at CAM interventions in media and community events. They should seek greater participation in health service programs and facilities jointly with medical practitioners, and they should participate and support validation projects in collaboration with health care researchers on a multi-professional basis.

These are initial suggestions for change. Other avenues for change undoubtedly will occur to you and should be actively pursued on a broad-based, multi-faceted approach. Thank you very much.

DR. GORDON: Thank you. What we have done here is we have given 10 minutes to the speakers, and it is really important that we conclude on time because we have a very tight schedule.

On the other hand, we have an ample amount of time, or a reasonable amount of time if not ample, a reasonable amount of time for questions. So we will be coming back to all of you for questions.

The next speaker will be Jennifer Engstrom.

MS. ENGSTROM: Good morning, everyone. I am a third year medical student at Case Western Reserve University School of Medicine. I have been involved in efforts to facilitate the integration of CAM education into traditional education, both at my own school and through the American Medical Student Association.

I want to thank you very much for your invitation. I am here to convey to you the medical students' perspective on CAM education.

As we all know, medicine today is experiencing a paradigm shift in what is perceived as fundamental to the nature and delivery of health care. Specifically, this involves a blending of two philosophies: biomedicine and holistic medicine.

An increasingly knowledgeable patient population is now seeking alternatives to conventional medical therapies. Patients choose to use CAM because

they find it provides relief from symptoms, promotes healing, and empowers them to take an active role in their own health care.

Recent trends indicate that over 42 percent of the general population use some form of CAM. Consequently, there is an overwhelming trend toward reforming health care education, research and delivery to better serve the needs of society. Furthermore, the AMA regards competency in CAM as relevant to and representative of cultural competence in health care delivery.

Medical students have expressed tremendous support for the inclusion of CAM within traditional core curricula. According to the 1999 AAMC Medical School Graduation Questionnaire, 63 percent of medical students rated their education in alternative medicine to be inadequate. Interestingly, this number has only improved by 3 percent since '98, despite the doubling of CAM elective courses offered at medical schools over the past two years, from 34 schools in '96 to 75 in '98. Evidently, CAM elective courses alone are not adequately preparing future physicians to meet the needs of their

patients.

A recent report by the AAMC on the Medical School Objectives Project calls for physicians to be sufficiently knowledgeable about both conventional and non-conventional forms of care. In order to accomplish this goal, medical education must begin to reflect a more integrative type of medical practice. Presenting information within the core curriculum does not constitute blind advocacy, but instead, prepares future physicians to critically evaluate the research literature and advise their patients accordingly.

Currently, less than 30 percent of patients who use CAM disclose this information to their physicians. It is important to note that patients properly counseled by a physician knowledgeable about CAM are more likely to reject modalities found to be unsafe or ineffective than patients who do not receive such counsel due to lack of physician education.

Education about CAM serves four major purposes: (1) to increase the cultural competency with respect to patient belief systems and cultural values; (2) to prevent contraindicated or deleterious care; (3) to

potentially improve the results of medical care beyond what might be achieved using either conventional or alternative medicine alone; and (4) to explore the potential cost effective alternatives to expensive medical technology, particularly when 70 percent of the health care budget is spent on chronic, debilitating illnesses, such as cardiovascular disease and chronic pain, both of which are particularly amenable to complementary therapies.

Incorporation of CAM within traditional medical education should involve cohesive integration across all subject areas. Limitations in time and resources are a reality at all medical institutions, and necessitate that integration by without tremendous increase in the volume of information to be presented so as not to detract from other core subject matter. Instead, medical students should be introduced to CAM as representing a wealth of potentially valuable health care models needing further investigation.

The following list outlines the main objectives which would be considered representative of a comprehensive CAM curriculum. These general guidelines

represent the interests of U.S. medical students, the NIH First National Conference on Medical and Nursing Education in CAM Therapies, the Society for Teachers of Family Medicine, the AAMC, and the Uniformed Services University of Health Sciences: (1) to define CAM and the modalities encompassed by this definition; (2) to facilitate and encourage medical students to reflect upon the issue raised by the growth and practice of CAM in scientific, clinical, and social contexts; (3) to introduce medical students to the historical development, philosophy and cultural origins of CAM modalities; (4) to provide students the opportunity to observe CAM practice so that they may formulate their own opinions about CAM; (5) to give students the opportunity to look at specific CAM therapies in more depth; (6) to consider the evidence base for CAM regarding safety, efficacy, and cost effectiveness; (7) to discuss the relevance of CAM in specific clinical situations, and this would include on indications, contraindications, frequency and duration of treatment, and costs; (8) to provide students with guidelines for appropriate referral to CAM providers; (9) to prepare medical students for practicing medicine

within the context of the multidisciplinary, integrative health care team; (10) to give students the training regarding medical, legal and ethical aspects, including licensing, referral and liability issues; (11) to provide students with opportunities to learn how to talk to patients regarding their health care believe system, which may include the use of CAM; and (12) to allow students to personally experience the underlying concepts of mind-body medicine from which many CAM modalities derive.

Medical students not only want access to CAM, they want to see CAM cohesively integrated into the classroom and clinical training. It is important to note that this does not imply that an exhaustive CAM curriculum be implemented overnight. Ideally, CAM education would be best integrated in two major ways: during the first year of medical school, it would be most appropriate to offer a general survey course to introduce students to the various modalities and provide an overview of the seven major CAM categories defined by the NIH.

Second, relevant CAM topics should be

integrated into traditional medical courses. Pharmacology should include evidence-based information on herbals and nutritional supplements, including potential benefits, side effects and contraindications. Ideas on energy-based medicine, including acupuncture and qigong, should be discussed within the context of neurology.

Case Western Reserve School of Medicine is one of a handful of medical schools which represents a potential model for comprehensive CAM education. Over 15 CAM electives are offered to first- and second-year students, including mind-body medicine, manual healing, and spirituality and healing. Lectures on acupuncture and psychoneuroimmunology are directly integrated into the core curriculum.

During their fourth year, students can also complete a clinical CAM elective in which they spend a month with various CAM providers. CWRU provides an area of concentration credit in CAM for students who complete a minimum of the aforementioned credits. Furthermore, 10 hours of CAM education is included in the Family Medicine Residency Program at university hospitals of Cleveland.

Future physicians need to become conversant in

complementary and alternative medicine so that they are more adequately prepared to meet the needs of their patients. Comprehensive CAM curriculum will not only serve to prevent deleterious care, but more importantly, it will facilitate the advancement of a new integrated paradigm for health care delivery, one which represents the best that both conventional and alternative medicine has to offer. After all, science is interested in increasing the accuracy of knowledge, not in the finality of opinion.

DR. GORDON: Thank you.

The next speaker will be Dr. Deborah Danoff.

DR. DANOFF: Good morning. Thank you very much for inviting me to be here. I am Deborah Danoff. I am a physician and assistant vice president in the Division of Medical Education at the Association of American Medical Colleges, and I appreciate the opportunity to speak to you on behalf of the Association of the American Medical Colleges.

The AAMC is a nonprofit association founded in 1876 to work for reform in medical education. The association comprises the 125 accredited U.S. medical

schools, the 16 accredited Canadian medical schools, over 400 major teaching hospitals and health systems, 90 academic and professional societies, representing nearly 100,000 faculty members, and the nation's medical students and residents.

The AAMC has as its purpose the improvement of the nation's health through the advancement of medical schools and teaching hospitals. As an association of medical schools, teaching hospitals, and academic societies, the AAMC works with its members to set a national agenda for medical education, biomedical research, and health care, and assists its members by providing services at the national level that facilitate the accomplishment of their missions.

In pursuing its purpose, the Association works to strengthen the quality of medical education and training, to enhance for biomedical knowledge, to advance research in health sciences, and to integrate education into the provision of effective health care. Today, the Association carries out a broad range of programs and studies to represent its constituents.

The AAMC recognizes the importance of an

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

We know that complementary and alternative medicine, hereafter referred to as CAM, has a significant presence in the United States. The AAMC has undertaken a number of major initiatives to assist our institutions in their review and revision of curriculum for medical students and residents. Some of this information has already been very ably presented by the previous speaker.

The Medical School Objectives Project, called M.S.O.P. or MSOP, was established in 1996 and has issued three major reports with an additional three reports due this year. Expert panels in consultation with major stakeholders developed these reports that focus on the education of medical students. In 1999, we also established a committee to develop a Graduate Medical Education Core Curriculum. We have also focused

specifically on CAM with the establishment in 1998 of a special interest group on CAM.

The following information provides some of the highlights of the reports I have just mentioned: The MSOP addresses directly the expectations for graduating medical students and makes concrete recommendations for educational objectives to assure that our graduates will be able to meet the needs and expectations of the 21st century. MSOP I, entitled "Learning Objectives for Medical Student Education: Guidelines for Medical School" sets forth 30 program-level learning objectives that represented a consensus within the medical education community on the knowledge, skills and attitudes that students should possess prior to graduation from medical school. It focuses on the attributes of physicians who are defined as being altruistic, knowledgeable, skillful, and dutiful.

Particularly relevant to your commission are the following specific recommendations that medical schools must ensure that before graduating, a student will have demonstrated the following: knowledge of the important non-biological determinants of poor health, and

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

MSOP II, "Contemporary Issues in Medicine: Medical Informatics in Population Health" identifies specific educational elements for educating medical students to have a population health perspective. This perspective encompasses the ability to assess the medical needs of a specific population, implement and evaluate interventions to improve the health of that population and provide care for individual patients in the context

of the culture, health status, and health needs of the population.

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

The Graduate Medical Education Core Curriculum Report identifies five domains of knowledge and provides examples of measurable educational objectives. This work closely parallels and complements the work of the Accreditation Council for Graduate Medical Education. The five domains defined in GME are biomedical ethics, scholarly medical practice, communication in medicine, medical professionalism, and the health care system.

Again, the following elements are of particular interest to the Commission: knowledge of differing ethno-cultural viewpoints and religious beliefs; the ability to

provide their patients clear information about treatment programs and options, health maintenance and illness prevention; the ability to serve as the patient's advocate; knowledge of the health care needs of the community; knowledge of community health care organizations and resources; knowledge of the principles of population-based medicine; the ability to work with social service and public health agencies, religious institutions, police and other community as appropriate in assisting their patients.

Following on the publication of these reports, the AAMC and its member institutions will be developing educational and evaluation programs to support these objectives. I hope that this very brief overview of some of the educational initiatives of the AAMC will be helpful to you. I have provided you with some information about the MSOP III Report, and will be glad to provide additional details if that would be helpful.

The increased attention paid to CAM in our medical schools mirrors the trend amongst American health care providers and consumers. All of our medical schools provide education about mind-body interaction through our

focus on the bio-psychosocial model of disease. We also provide specific instruction on the pathophysiology of disease, as well as attention to disease prevention and health promotion.

In addition to these general educational experiences, a significant number of schools provide teaching about CAM. Data from the 1998-99 Liaison Committee on Medical Education, LCME, school report indicates that more than 75 of the 125 schools provide this education. Seventy-four schools provide this as part of a required curriculum. Sixty-three schools provide it as part of an elective program.

A sampling of offerings in 2001 include: Overview of CAM; Human Values in Medicine; Prevention of Injury from Herbal Medications; A Scientific Look at Alternative Medicine, Patient-Centered Care. Schools are developing both required and elective programs that focus on a wide range of topics.

Information on teaching in the more than 7,000 graduate medical education programs is not as well defined. We know that particularly those programs in primary care are incorporating this teaching into their

residency education programs. It should be noted that the ACGME recently established core curriculum requirements that emphasize the need to deal with diverse patient populations.

The AAMC recognizes the importance of exposing medical students and residents to education about CAM. Physicians need to be well informed about the conceptual basis, efficacy and safety of alternative therapies. They must be aware of the potential value, as well as the complications of CAM therapies, and of the potential drug interactions that can occur between herbal preparations and standard pharmaceuticals.

They need to be able to obtain accurate information from patients about their use of these therapies. In addition, physicians must be able to assist their patients to make informed choices in health care, and thus to be able to discuss CAM in this context.

The foundation of this education should occur in medical school, with further development as appropriate in residency training. We also support the need for scientifically rigorous, high-quality research on alternative modalities to provide a basis for

evaluating their safety and appropriate use.

The AAMC and its member institutions are committed to improving the health of the public. We belief that the focus should be on evidence-based medicine, regardless of origin, conventionality or approach.

I hope the information that I have provided today will be of assistance in your deliberation, and I look forward to responding to your questions.

DR. GORDON: Thank you very much, Dr. Danoff.

There are additional questions that Dr. Danoff and Dr. Jordan Cohen, President of the AAMC, responded to. I refer commission members to those answers, which I think are very helpful.

Dr. Peter Scoles.

DR. SCOLES: Thank you. I am Pete Scoles. I direct examination programs at the National Board of Medical Examiners.

Jennifer, let me apologize for causing you so many sleepless nights this spring.

[Laughter.]

DR. SCOLES: Now, I am an orthopedic surgeon.

I am happy to be addressing alternative medicine today, and not alternative surgery. Let me start with a few words of background about the National Board and the U.S. Medical Licensing Examination.

The National Board of Medical Examiners, located in Philadelphia, is a nonprofit organization founded in 1915. Our mission is the production and delivery of valid and highly reliable examinations for the health care professions.

In addition to the USMLE, the National Board provides examinations for professional organizations and specialty boards that certify physician specialists, physicians' assistants, physical therapists, and in fact veterinary physicians.

The USMLE is the largest examination program operated by the National Board. The USMLE is jointly owned by the Federation of State Medical Boards and the National Board of Medical Examiners. I belief that Dr. James Winn, Executive Vice President for the Federation, will be speaking with us this afternoon.

The purpose of the USMLE is to assess the physician's ability to integrate basic science and

clinical medicine to provide safe and effective patient care. The USMLE is the only pathway to licensure for physicians who are graduates of accredited medical schools in the United States and Canada. All graduates of international medical schools seeking licensure in the United States must also pass the USMLE. Finally, a growing number of osteopathic medicine also take the USMLE.

The NBME provides content outlines for each step of the USMLE, but it does not provide detailed information on content distribution. Further information on the examination is available on the CDs that I have provided to the ladies at the front desk. There are sample examinations for Step 1, 2, and 3 there for you. We will not score those.

USMLE has a very powerful effect on undergraduate and graduate medical curriculum design. Although it's not the purpose of the examination to drive course content, medical school faculties predictably pay very close attention to content areas covered by the examination. Student study materials they belief will be included in the USMLE. Many students enrolled in the

review courses offered by test preparation companies, not surprisingly, those companies base their courses on their best guess of USMLE content.

The examination certainly has a secondary effect on the practice of medicine. Doctors practice what they have been taught. It is essential that the National Board avoid the perception of unproven, ineffective, or unethical methods of treatment.

State medical boards rely on USMLE to certify that a physician will provide scientifically based and ethical care. They must be assured that the materials contained in the examination are based on sound principles and scientific reasoning. If items regarding alternative therapies are included on USMLE, they must be held to the same standard of evidence as traditional therapies.

Let me turn now to the current status of CAM on the USMLE. As you have heard, the AAMC Report on Medical School Objectives emphasizes that physicians should be sufficiently about traditional and non-traditional modes of care to provide intelligent guidance to the patients.

Staff at the National Board and members of the

governing committees for the examination concur with AAMC conclusions and recommendations. The governing committees of USMLE reviewed covered of CAM last summer with the assistant of Dr. Wayne Jonas, a member of this panel. I must tell you that the depth of CAM item pools in USMLE is not great.

Based on this review, USMLE governance has made initial recommendations for further development of content areas. Pathophysiologic processes, principles of pharmacology, evaluation of the effects of therapy, and patient communication skills, all fall within current content and task outlines at the USMLE.

General areas in which CAM could be included in the examination include: (1) evaluation of communication skills; (2) the side effects and adverse drug interactions associated with herbal and alternative medications; and (3) critical evaluation of medical literature related to CAM.

Our Step Committees have made specific recommendations to NBME staff. The Step 1 examination is concerned with, basic science is fundamental to the practice of medicine. CAM coverage in Step 1 currently

includes a very small number of items related to pharmacology.

The Step 1 exam pool could be expanded to include questions on alternative therapies for which mechanisms of actions have been established. In addition, the exam could include questions about adverse drug side effects and the interactions of medications with other pharmaceutical agents. On the other hand, areas in which evidence for efficacy was based on less than rigorous research should be avoided until further studies are complete.

The Step 2 examination assesses the ability of a physician in training to practice in a supervised environment. There are currently a limited number of CAM-related items in the Step 2 exam pool. The Step 2 content outline could incorporate additional CAM items.

Since students who take the Step 2 examination encounter patients in out-patient clinics, hospital settings, and emergency departments, communication skills are essential. Questions which probe side effects from self-prescription, drug interactions, interpretation of medical literature, and the reaction of physicians to

patients who use CAM are all relevant.

The Step 3 examination assesses competency to provide unsupervised general medical care. The Step 3 Committee believes that it is essential to emphasize the scientific basis for practice and to avoid the perception of endorsement of unproven methods. The Step 3 Committee recognized the need to respond to new content areas to patient-driven concerns. They identified five areas where CAM therapies could be included. These were: history-taking; communication skills; medical effectiveness of alternative therapies; side effects; and drug interactions.

In conclusion, it appears that given the frequency of the use of CAM and the potential for severe drug interactions and side effects, it appears reasonable to include items related to CAM on USMLE. We could take two approaches to this. We could employ our current protocols to appoint basic scientists and academic physicians with interests and expertise in CAM to our test material development groups. This vacancy is open over the course of the next four years. This is how we usually incorporate new areas.

They would be allowed approximately four years before items that were developed appeared as live test questions on USMLE. Alternatively, we could assemble a special task force to rapidly develop CAM materials for all three steps of the examination. A CAM task force that met for three years could be expected to add 600 to 900 items to our examination pools, with the first live items becoming available in a year and a half to two years.

The three-year cost estimate for this would be approximately $200,000. The cost of such an effort must be weighed against competing pressures to broaden coverage in areas such as end-of-life care, pain management, and domestic violence. Foundation funding can assist in deepening item pools quickly, but I must point out that it never influences examination blueprints.

Thank you for the opportunity to review this with you. I would be happy to answer further questions about USMLE in the question-and-answer session.

Panel Discussion

DR. GORDON: Thank you very much.

We now have a chance for questions. Wayne, do you want to begin?

DR. JONAS: So many wonderful presentations. I want to thank Dr. Scoles. I was at that meeting, and I was very impressed by the interest of all the groups and their active involvement and depth of knowledge in these areas, actually. The proactive steps that you are taking, I think, will have a major impact on what goes into the curriculum and what goes on the tests, and I will never curse a question again that I see on some of those -- well, maybe never.

[Laughter.]

DR. JONAS: Maybe never. I guess, the key issues that kind of cut across a lot of these areas in my mind have to do with skills training. I think it is pretty clear that information, communication skills, cultural competency, and a number of items that are already part of what we would like to see physicians, and any health care practitioner, be part of or have skills of, need to also address areas of CAM.

But then when we get to the area of provision of care: Should I prescribe an herb; should I deliver

acupuncture; et cetera, et cetera, it becomes a little bit more problematic. For example, P-6 acupuncture for nausea and vomiting has been shown to be safe and effective.

How can we make these available? That is a skill-based type of thing. How does that come into medical education, would be my question. I think that is the most difficult area that we would need to examine.

That would be my first question. Then I had one specific question for Dr. Orzack. I am wondering if anyone would like to comment on how that comes about, or if there are ways in which your organizations and activities can incorporate a skills-based training provision of care, rather than simply knowledge.

DR. DANOFF: I will make a stab at answering that. I think that one must recognize that medical education occurs over a continuum, and that in becoming a skilled practitioner, we are talking about an extended process.

In undergraduate medical education, the focus is clearly on teaching people about things, as opposed to the specific skills of doing things, other than very core

diagnostic and therapeutic activities. We constantly wrestle with the fact that therapeutic activities are very appealing, and in many cases we try to point out to students at the undergraduate level that the focus needs to be on understanding what the underlying principles are and some of the other aspects of medical education.

I would therefore say that the specific example which you have given would be something that I would anticipate would be appropriate at the post-graduate level, the residency or fellowship level, directly related to the modalities where it would be used.

So, for example, if you are talking about a modality that would influence pain management, then I would anticipate that that would be taught in residency programs where that skill was taught along with other skills, like brachial block or any other techniques that might be used for pain control.

DR. JONAS: I think it would be very useful to see some of that spelled out in a little bit more detail in some of these areas. To elaborate on the skills development, I think, would be very useful to clarify those things. I continually think that evidence-based

approaches and clarifying what we mean by that, and making that the lead area, as you have done with GME, and a number of people have mentioned today, is the key approach to really covering many of these areas. So I just want to emphasize that.

Ms. Engstrom, would you like to see some kind of specialty training, post-graduate training, residency training, for example, in some of these areas? Would that be something that you think that would be of value?

I know there are some programs that are trying to be developed along those lines.

MS. ENGSTROM: Right. There is a fellowship for integrative medicine. I think that is a appropriate and useful for physicians who come out of primary care residency programs who want to gather some more experience in practicing integrative medicine, whether they practice each individual therapy that they learn in that fellowship or not, or whether they just learn the appropriateness of a referral to different CAM providers.

I think that at this point it would be beneficial to include CAM skills and further training in residency programs. I think that in the future there

will be a residency program geared more toward integrative medicine, and not as a separate fellowship. I don't see that happening in the near future, but I do think that things will go that way.

As far as right now, I believe that the most appropriate way to deal with this is to provide more education and skills training at the residency level, and make it part of the core curriculum in the residency programs, and also have elective time for residents who want to learn about particular modalities, so that they can spend a month, two months, learning about acupuncture or herbal therapies, and also learning about the programs that are available, such as the Helms course, that they can take to get further education on specific modalities.

DR. GORDON: Dr. Orzack?

DR. ORZACK: I don't know if this is working, but I will speak rather loudly. The approach that I would urge on you is to view this not only in terms of skills, but also in terms of responsibilities. The responsibilities, aside from medical students, medical residents and so on, they also have to do with medical practitioners who are out there.

I will throw a question at you. What can be done for continuing medical education for the, I don't know, what is it, a couple of hundred-thousand medical doctors who have already been educated, most of whom, I guess, have gone through residencies already? They are beyond that point.

What would be the role of the licensing boards, the regulatory agencies? Will they be expected to require CE work, continuing education work, in CAM by medical practitioners who are already out there?

I don't know the answer to that. I suggest that you might want to deal with that.

DR. GORDON: Thank you.

DR. JONAS: I just wanted to ask Dr. Orzack one question.

Actually, you have partly addressed it already. The vast amount of knowledge and information that is behind what you presented, I am almost embarrassed to even ask a question in these areas, but my summary of this, as you have implicated right now, is that the process by which professions emerge and become established is largely, number one, getting their act

together about accountability and responsibility, as you have mentioned, and then a maneuvering around to establish themselves in that area, and then a gradual process, a very complex process, of public acceptance.

Is that a reasonable, simplistic summary of what you were saying?

DR. ORZACK: It is a reasonable, simplistic summary, of course. One of the matters that you must add to that, or must keep in mind, is the matter of time frame and method. While it hasn't been mentioned here, and I don't know whether I had an opportunity in my remarks to deal with it, but it is in my written text, I am not holding this out as a prototype, the desirable way to go, but in that field of audiology that I mentioned, they went to court, and now there is a legitimation been given to a doctor of audiology degree, which will complement the master's level accreditation.

That court settlement occurred last year, and a number of universities are lickety-split setting up AUD programs. Sooner or later, very shortly, I think, you will see, probably, pressure on the state legislatures and the licensing boards and so on to change their

licensing procedures and the administrative procedures to allow doctors of audiology with that degree to practice. There are a lot of ways of doing this. Time frame is one of them.

If I may take one more second, I think it is a matter of responsibility. What will be the responsibilities of the health care providers, medical doctors and others, 10 years from now? I think that could well be a starting point for your work.

DR. GORDON: Thank you. I am going to ask one question, and then Tieraona and Dean.

The question I have is for Dr. Danoff and Dr. Scoles, in particular. The way the reference to mind-body medicine, for example, is presented is as an academic subject that one could learn regarding the research evidence and the physiologic connections.

One of the things that I found in teaching in medical schools for many years is that students very much appreciate the experience of the mind-body connection through relaxation techniques or biofeedback or imagery.

I am wondering if either of you has given thought to seeing that as an area to encourage for

medical students' self-care and self-knowledge, as well as for teaching to patients.

DR. DANOFF: I think the issue of the bio-psychosocial model of disease and the issue of mind-body interaction is one that is being increasingly addressed in the medical curriculum.

One of the other elements is the issue of self-care and wellness for practitioners. I think that in that realm there is already a fair amount of discussion about the need to teach behavioral modification activities that may be of benefit to individuals.

DR. GORDON: Great. Thank you.

DR. SCOLES: I think there is something paradoxical about speaking about relaxation techniques and examinations in the same breath.

DR. GORDON: I always thought they went together.

DR. SCOLES: For the successful students, I am certain they do.

The National Board is studying incorporation of a standardized patient examination, a test of clinical skills, in the USMLE: should we integrate and deploy that

examination as part of the USMLE sequence. That 10-case interview examination should give us the opportunity to explore lots of these kinds of areas.

It is not live yet. It will be several years before it goes live if it proves to be practical, but that is a vehicle to do this.

DR. GORDON: Great. Thank you.

Tieraona?

DR. LOW DOG: I think this is for Dr. Scoles or Dr. Danoff, either one. I am just curious, when we talk about evidence-based, there actually is more evidence then I think we are willing to contend, and actually some of it quite good; a lot of it, not.

My question is, for instance, saw palmetto. We had meta-analysis in JAMA. The USP came out with a favorable monograph on saw palmetto once. We reviewed the evidence, including a panel of experts of urologists. Glucosamine, we have had a meta-analysis. "Lancet" just now came out with a, really, pretty well done study, looking at, this actually may be a disease-modifying agent in osteoarthritis.

So when we have the evidence, it does appear

that if it is not from a pharmaceutical company or it is not being driven through the channels that we normally go through, that on some level there is a considerable log time to introducing that into curriculums or testing.

I am curious how we are going to get past that. When there is evidence available, it seems if it has less side effects, it is less costly, why we are not introducing those to formularies, why medical students aren't learning about it in medical school when we learn about all the rest of the drugs that we are learning about. It seems almost as if there is a two-tiered system, and I just wondered if anybody could comment on that.

DR. SCOLES: Well, I think in terms of licensing examinations, there is a built in lag time, an unavoidable delay, between concept and implementation of an item that is scored on an examination. The psychometric characteristics of examination-building almost mandates a four-year delay period before an examination item can actually be counted against the score of an examination. It is the nature of the beast.

There are growing bodies of evidence, reliable

evidence in some of these areas, and those increase, they will be incorporated in examinations, but I think we will have an unavoidable delay in inclusion of examination items.

DR. LOW DOG: Will those be treated as CAM? I guess I am always confused. Is a rheumatologist who prescribes glucosamine a CAM provider? Or is he just somebody that is a good doctor, who has read the evidence in peer-reviewed medical journals who is using the best medical care for that individual patient? Do you have to have a CAM group come together that are specialists in these fields to be able to integrate some of these things into the testing?

DR. SCOLES: No, I don't think so. Many of these areas are currently covered in our content blueprints and our examination outlines. The model that we build the examination around, the fundamental architecture, is the 100 or so most common reasons that individuals come to physicians for in the United States, modified by expert judgement for high-impact but low-frequency occurrences, and adjusted for basic science in preclinical curriculum. Most of the therapies that you

speak of fall under that umbrella and can be included in that umbrella.

DR. GORDON: Dean, and then Charlotte, and then Joe.

DR. ORNISH: Well, I also want to thank the people who made presentations, and [say] how much I enjoyed hearing them. I have just two brief questions. The first, for Dr. Orzack.

Part of the function of professions is to create standards and accountability, as Dr. Jonas mentioned also, but also part of it is to create exclusion, either by legislation or by jargon and so on. You gave two examples of the audiologist versus the NT, the optometrist versus ophthalmologist, and the growing tendency of legislation that allows them to function more or less autonomously.

One of the recurrent themes that we hear in the various testimony before us is, should CAM be done through a primary care physician that then brings in other acupuncturists and massage therapists, et cetera, or should people be able to get reimbursed autonomously of a physician.

I am wondering, can we learn anything from the experience that you described with the audiologist and the optometrist, by analogy?

DR. ORZACK: Do I have to answer that question?

[Laughter.]

DR. ORZACK: I really would have to think about it and take another look at a lot of material I have, because I have written in both those areas. I am not really sure how to deal with that. I think you may have to, again, think in terms of a long time frame with incremental changes.

I don't know if that is totally unsatisfactory. I mean, I ought to be able to whip out an answer, but I am not sure I can.

DR. ORNISH: Well, we can talk later.

DR. ORZACK: I would like to.

DR. ORNISH: For Dr. Scoles, a quick question. You outlined two methods here, two approaches, one of a four-year lag time of basically using the conventional methods that you do now but, just, including broadening the scope of it, and the other would be calling a special commission together.

The first question is, why does it take four years? Is that something unique to CAM, or does it always take four years for any board question? And if so, why such a long time?

Second, is, of the two approaches that you outlined, which do you prefer and why?

DR. SCOLES: Well, it takes four years for an item to become live because there is an initial cycle of identifying an item assignment, then writing the assignment by a test author, then review of that item by a group of peers, then pretest of that item in an examination pool until a sufficient number of reference candidates have taken the item, then calibration of its statistics, re-review of the item, and then inclusion of that item in a test bank, and then its random selection for an examination that a student might take. That cycle is a three- to four-year cycle.

We can cut a year off that cycle. We can move it from four years to three years, to a live pool, if we shorten the item assignment/item writing period, and bring people, actually, together in Philadelphia to write the items instead of having them do it on their home

territory and send them in.

I would probably prefer that we follow our standard protocols in this area and begin to integrate individuals with knowledge in CAM into routine test committees, so we have a broad distribution, and therefore higher acceptance of the items in the examination.

DR. ORNISH: Thank you.

DR. GORDON: We are already at our time limit, so if we can have one quick question from each of Charlotte, Joe, and George. The we definitely have to close.

SISTER KERR: Thank you. Thank you for your presentation. When I often hear people speaking about including CAM in educational settings, particularly medicine, I often hear the emphasis being on how to introduce modalities.

Some people who have been in this field -- we heard some of them in New York -- those who have been in this for quite a while said they really had come to the conclusion that the emphasis should be on foundational work at the conceptual level, paradigm change.

Jennifer, you spoke to this.

Even at the level of speaking about new epistemology. So for me, the question becomes, what do you think about that? And my concern is that I don't hear that emphasis when people present. My own bias is, we need to be talking about it at the level of history of medicine, the philosophy of healing.

Jennifer, you mentioned acupuncture, for example, being under the Department of Neurology. I would put it under the Department of Energetic Medicine, along with homeopathy, and maybe some other things.

We need your help. How will we do this? I didn't hear this emphasis at all this morning, although I heard incredibly beautiful, clear presentations. Please give me some advice on this. Thank you.

DR. DANOFF: Perhaps my presentation was clear but not complete. Certainly, the underpinning, both of the Medical School Objectives Project and the GME Core Curriculum are indeed is issues related to foundational aspects. Tat is, an understanding of belief systems, of values, and of how those belief systems and values influence how we perceive health and illness and how we

approach both disease treatment and disease prevention.

So if the impression is that we would focus specifically on modalities of therapy, I think that that was a mispresentation on my part. I think that the principles are clearly very important ones, and indeed the principles allow you to make subsequent modifications more easily than if you are just teaching about a specific modality, rather than understanding the context in which that modality might be considered. So I do think that the basic belief systems are very important.

If I may take one moment to comment on curriculum development, because that question was raised before. The medical schools and residency programs constantly revise curriculum. So every year, if you look at a specific lecture or a specific series of lectures, changes have occurred.

The problem is that, depending upon how you look for change, you may not be able to see it over a prolonged period of time. If you change a curriculum, the student in the first-year curriculum, that will not be apparent for four years, until that student graduates from medical school.

If a single lecturer changes a particular element within their course, for example, a rheumatology lecturer introducing new modalities of therapy, your students may learn that but that may not be apparent if you do an overview. If you said to people, well, what have you changed in your curriculum, they might not even think of that as an issue that they should be bringing forward.

So I think it is a little bit like the diagnostic procedure of biopsy versus excision, if I may use that example. Part of the issue, when we think about medical education and changes in medical education, is, what is the granularity of our inspection of those changes, but I can assure you that change goes on constantly.

On a macroscopic level, we can see that over the last four to five years, the number of schools that are including issues related to complementary and alternative medicine, or issues related to end-of-life care have changed significantly. So there is change occurring, and it does occur constantly.

DR. ORZACK: If I may complement that, there is

a great deal of change in the knowledge incorporated in practice in all professions. There is also a great deal of resistance. There are rivalries among professions and providers.

Certainly, as a university professor, I would like to candidly admit there is a lot of rivalry among academics. How much time will be spent in my program compared to how much time you want. You are going to take something away from me.

So I think there are a lot of issues in this. Again, there is no simple answer to that intriguing question, and broad-based question, that you asked: How does change occur and how may it occur.

DR. GORDON: Joe?

DR. PIZZORNO: Actually, my question was answered.

DR. GORDON: Okay. George.

MS. ENGSTROM: I would like to make just one final important point on this topic. I think that is an important task of the Commission, to try and convey to the medical community and medical schools, and to acknowledge the evidence base of CAM, and also the

relevance, both philosophically and conceptually, to facilitate the efforts of educators at medical schools who are currently trying to implement these changes, because there is a lot of resistance. I think it is a task of the Commission to try to convey this, to facilitate the forward movement of this.

DR. GORDON: Do you have a specific suggestion for doing that?

MS. ENGSTROM: Just making sure that the policy recommendations are disseminated properly throughout the medical community, to support the efforts of educators at each institution.

DR. GORDON: Thank you. George.

DR. BERNIER: I would like to follow up on that, Jennifer. Very clearly, there has been a very strong national push on the part of the medical students to see change occur in this area.

Do you feel you could identify a major driving force that has pushed students to try to adopt CAM-related curricula?

MS. ENGSTROM: I think the main driving force is that medical students come to medical school wanting

to help people, and they see in their communities people that they know using these modalities. They use them personally. They see the potential of them. And so, I think that is where it comes from. When you come to medical school, you have a very open mind.

One interesting thing that I noted when I started the Integrated Medicine Interest Group at Case Western, each year the enrollment became larger and larger and larger. What was interesting was that students who had already completed one or two years of medical school were much more resistant to CAM.

I can't make that point enough, that we need to expose medical students and future health care providers to CAM early with the philosophy behind them and the concepts, going back to the history of medicine, all of that, early, so that we come into this with an open mind, and with that open mind, we can then look at the research literature, and then proceed from there.

DR. BERNIER: Thank you.

DR. GORDON: Thank you all very much. We really appreciate it.

The next panel.

MS. CHANG: The next panel is Dr. Alfred Fishman, Dr. Geraldine Bednash, Neil Sampson, and Sara Collina, please.

DR. GORDON: While the panel is getting seated, I am going to ask the Commissioners to, please, just ask one question to begin with. Okay? That way, we will make sure that everybody has a chance, and if there is time left over, you can ask additional questions.

MS. CHANG: We would ask that, speakers, if you could look in your folders and take out your name tags, and go ahead and put them up on the tables.

The speakers who have left, if you could leave the little insert, the plastic piece, so that the next person can put their speaker thing up. Thank you.

DR. GORDON: Dr. Alfred Fishman. Nice to see you again.

DR. FISHMAN: Thank you very much for inviting me back. There was a lot of discussion at home about whether this was a chance to redeem myself for the last performance.

[Laughter.]

DR. FISHMAN: But I am very pleased, and thank

you. I enjoyed the previous communications. They have a personal touch. For example, I am on the Board of Visitors of Case Western Reserve, and we are going out there, I think, next week. I am going to ask to review what they are doing on CAM. So it has already been a productive session for me.

DR. GORDON: Incidentally, Dr. Fishman's submission can be found behind Tab 30, for those of you who are looking at it, under Discussion Group 1.

DR. FISHMAN: Now, I have been asked to deal with two questions. One was to provide some sort of a summary of a Josiah Macy meeting, which I will come to in a minute, and the second is, including CAM in the medical education programs, who should fund it.

To put my presentation into perspective, let me make one comment at the beginning. As I listen to the individual people advocating one aspect of education over another, I realize how different the approaches are from institution to institution. I sympathize with a commission that has to generalize from particulars. For example, Case Western is different from the Harvard program, which is different from the Penn program. I can

go right on through.

So homogenization is not an easy task without losing the flavor of what you are trying to do. So what I intend to do is tell you, as a continuum, of what we have been trying to do at one institution. I think that the credit, if there is any credit, belongs to the previous dean who said, if we are going to look at CAM and where it fits into the academic health center, we are going to do it as though we were creating a new department or an institute, and therefore we are going to do it through a working group, through reviews. It has to go up through the provost, to the president, and it has to involve the faculty.

So this is now the end of three years of this kind of an effort, and this relates to the Macy Conference because Dr. Osborne was called in halfway through our proceedings to review what we had done up to that point. Dr. Osborne, who was raised as a microbiologist, infectious disease expert, et cetera, and who came in very much as a doubting Thomas, was convinced that this was something that had to be taken into account, and that led to this Macy Conference.

I should also point out that in the process, we had a cosponsored conference with the NIH on the ethics of complementary and alternative medicine. So that, we have taken each step separately.

Now, I won't go through this. We have established how you introduce academic practices into the system, what are the legal issues. We have a process for accepting or not, just as though you were doing brain surgery: Do you accept acupuncture, or don't you; what are your credentials; how were you evaluated. We have been fortunate in being able to do it without disrupting the system.

Now, about the Macy Conference, several people who are on this commission were present. Let me just give you a very quick, bird's eye view. It was a meeting, as a Macy meeting always is, with about 30 people or so, consisting of consumers, practitioners, deans, physicians, other health care professionals.

What was the purpose? Well, it marked the end of our three years of our research on how we do clinical, education and research. But the key question is, how do you integrate CAM; what are the challenges to medical

education.

To cover these topics, incompletely, we dealt with the history and the ancient roots, research on safety and efficacy, quality control, but the big emphasis in the meeting turned on what it was that you could have of added benefit to the existing faculty, and one of the biggest advantages could be in appreciating multiculturalism. That was a topic that was discussed again and again. In fact, we were accused of oversight in the medical curriculum. And so, this has been turned to great advantage.

What were the common themes in there? One that impressed me, that you may see in the write-up, was the concept of humiliation. I had never given this very much thought before. The concept of humiliation by a psychiatry professor, as you can tell, was that both the physicians and the patients are humiliated by the encounters.

The physician has been beaten over the head by HMOs, by hurry-up-and-do-this-quickly. The physician feels degraded. The patient feels as though the patient has a secret that he or she is withholding from the

physician. So the bottom line is that there has to be steps taken to overcome barriers to communication.

And then, we went through a whole series of how inadequate scientific medicine in dealing with the whole person, the problem of caring. One of the things that came out, and really is passed over lightly here, too, is the problem dealing with herbs. It is almost impossible to do good research until somebody standardizes what an herb is. Therefore, you can have somebody spending a lifetime studying ginkgo, and find that that preparation is not like any other ginkgo preparation in the world, and therefore the results are not particularly generalized.

Anyway, we will go on. So the conference moved ahead to conclude that science-based medicine and CAM have a lot to teach each other. Another point that was made repeatedly is, medical practitioners, in the way they approach patients, don't really have a good understanding of the placebo effect and how to use it well, because most of the emphasis in the literature is what goes wrong when you take this or you take that, et cetera, what interferes.

Well, what are the practical aspects? Everybody agreed that we need more research and greater accountability.

With respect to recommendations, I will just skip very lightly. One, formal courses were held to be unrewarding. You sit there in a big amphitheater and lecture at students. It is like ships passing in the night. So that, again, comes back to the point is different schools teach in different ways.

The other thing is, don't teach the physicians to be practitioners of the different modalities. That should be later. Let them understand what is going on rather than how to do it. That doesn't mean they shouldn't observe. They can attend, they can witness, they can do everything you want, but they really should catch the meaning behind it, the concept behind it. The other thing is, you must use CAM to promote the art of communication and listening. That was a theme again and again, and there were some recommendations which are detailed over here.

For shortage of time, and I haven't done justice at all to the meeting, I would like to address

the question of whom and how to teach. When we went through it, we said this is a very big problem because you can't talk about funding until you know whom you are teaching. Well, the first group we wanted to teach was the public. I have some brochures here. At the College of Physicians of Philadelphia, we set up as part of this distinguished library and building, a room, almost this size, which is a walk-in library.

Anybody can come into it. There is a librarian, a computer for storage and data retrieval, et cetera. So if you came in and you said, "I would like to learn something about an herb," the librarian would help you, et cetera. The CDC came to review it, has endorsed it.

At the moment, what we are doing is we are communicating with the public library system of Philadelphia to introduce into the libraries replicas of this particular station so that anybody can walk in and get health information which includes complementary and alternative therapies. If any of you all are interested in that, the building is magnificent. It is worth a visit.

So that is the public. The college students, we had a great time in introducing what we think is CAM in sociology, anthropology, folklore and history. The students love it. They have some of the people who were trained in complementary/alternative therapies come down and talk to them about what they are giving in folklore. Suddenly, they say, "Oh, my god, that goes right on to the present time, doesn't it."

So, at any rate, we have invaded the universities and we have been well received. Honest, they have given us banquets.

[Laughter.]

DR. FISHMAN: But the big thing that you are asking about is physicians, and there are, again, different categories. There are four that we identify: The medical student is easy; the residents, not difficult; academic physicians, tough; practicing physicians, near impossible.

[Laughter.]

DR. FISHMAN: That calibration is unofficial, but I tell you, the medical students we have had, as I said before, an attempt to devise a curriculum at Penn,

which is unusual, for the last three years. As a result, we have got working groups that are trying to say what goes into the curriculum. Therefore, it has not been difficult to say, where does CAM fit.

Well, in the first year, you fit CAM; new students; new faces; what is professionalism; what are the cultural backgrounds of what we are doing; what is the Hippocratic tradition; are we living up to it; what is the impact of having HMOs, et cetera, driving you wild so you have too little contact time.

Quit? All right, I'll quit. Then, I won't go anymore.

I just wanted to tell you, by strategic bombing you can incorporate at each specialty. For example, orthopedics, orthopedics give lectures on it. Acupuncture, the people who are acupuncturists do it. Mind-body and psychiatry, there are sessions. In pharmacology, there are discussions of herbs where they are relevant. So this is all built in because of the system.

The only point I would make in concluding is that, when one talks about education and generalizes from

single models, it is very difficult. I wish that this Commission could do site visits and actually take a look and see some of the things that are going on, because it is impossible to portray them in a brief presentation like this.

Thank you very much.

DR. GORDON: Thank you very much.

Dr. Geraldine Bednash.

DR. BEDNASH: Good morning. Thank you. I am Geraldine Polly Bednash, more commonly known as Polly Bednash. I am the executive director of the American Association of Colleges of Nursing. Our organization represents over 550 senior colleges and universities that offer baccalaureate and graduate degrees in nursing.

I am pleased to be here today to provide you with some comments related to nursing education, the nature of the education for professional nursing practice, and the types of issues that face nursing educators when they are addressing the subject of complementary and alternative medicine and therapies.

As part of my remarks this morning, I was asked to provide you with a brief overview of professional

nursing education. As many of you may know, there are a variety of ways that an individual can be prepared for entry-level professional nursing practice. This morning, however, I will address the baccalaureate and master's degree program characteristics as part of my remarks. Over 550 senior-level colleges and universities in the U.S. have baccalaureate nursing programs that prepare for entry-level practice. In addition, a master's degree in nursing is offered in almost 400 institutions.

The typical baccalaureate nursing education consists of four years of study with the first two years focused on the general studies, the core of physical and social sciences course work, and the liberal arts. Nursing course work begins, typically, in the second year of the baccalaureate program, while a small percentage of the students are given course work in the first year.

Nurses prepared for entry-level practice in baccalaureate programs are typically awarded a bachelor of science in nursing. These graduates are prepared for practice in complex environments that demand systems competencies, critical thinking and analysis skills, and the ability to function in teams and in ambiguous

environments.

The master's degree-educated nurse is prepared for advanced practice with the greatest portion of these receiving preparation to serve as a nurse practitioner. I, myself, am a nurse practitioner. Over two-thirds of all master's graduates are prepared in this role. Other roles at the advanced level include preparation as nurse midwives, nurse anesthetists and clinical nurse specialists. That curriculum is typically one-and-a-half to two years in length and, after graduation, these nurses typically sit for certification in their area of specialization.

Nurses prepared at the baccalaureate-entry level and at the advanced-practice level each must have both an awareness of the potential for complementary or alternative therapies to be a part of the patient's armamentaria of self-care interventions and must have an ability to assess how these therapies are either complementary or potentially harmful to the patient.

Our organization has developed standards for both baccalaureate and master's level education in nursing. In each of our standard documents, we

explicitly note the requirement that thorough assessment of the cultural, lifestyle and multiple therapies are a basis for any interventions by the nurse clinician. In addition, we have an explicit standard that the student must develop an awareness of complementary modalities and their usefulness in promoting health.

Unfortunately, however, there are great gaps in the available science for nurses and other health professionals who attempt to assess the utility of these therapies or provide advice and counsel to the patients for whom they care. Nurses, like other health care professionals, are acutely aware of the growing practice of consumers to self-select a range of complementary therapies or to seek consultation from non-traditional health care providers.

This is a recent issue, for instance, of "Nursing Spectrum." "Nursing Spectrum" is a Gannett Corporation publication that is circulated free to over 1 million registered nurses. It focused on the issue of complementary therapies and provided for the practicing nurse a range of resources to be used in assessing these therapies.

The American Holistic Nurses Association has published guidelines related to the curricula for CAM. In addition, a number of nurse educators have designed tools for the education of nursing students to assist them in making evidence-based decisions about interventions related to CAM therapies.

At a minimum, nurses must be prepared to advise patients and their families who use self-selected CAM therapies and practices. They must have a core of evidence-based content for their practice and must be able to evaluate critically the best evidence available on any new therapies.

At the University of Virginia, Dr. Ann Taylor, a professor in the School of Nursing, directs the Center for Study of Complementary and Alternative Medicine at that university. She notes that a major deficit faced by nursing and other health professional educators is the lack of a significant base of data on these therapies, and comments that even existing resources are quickly outpaced by the emergence of new alternative practices or therapies. In addition, much of the content given to nurses and other health professionals is limited in its

focus and often exposure to this content depends upon the availability of an interested or concerned faculty member.

Our organization would not support the establishment of a requirement that a specific and separate course in CAM therapies would be required for all nursing students. However, we do support the need to have clear and consistent information provided to nursing students about these therapies in the full range of course work that the student experiences.

I agree with you, Dr. Fishman, on this issue.

This Commission could make a significant contribution to the education of all health professionals through a recommendation that an easily accessible and evidence-based resource of data on these therapies be made available to educators and clinicians. The use of the Internet can assist not only the consumer of CAM therapies but also can assist the provider who is attempting to intervene or consult successfully.

The major barrier to successful education on this important topic is more likely to be overcome through a widespread education program for faculty and

clinicians and through the development of sophisticated resources for effective interventions.

The work of The National Center for Complementary and Alternative Medicine at NIH is central to this. Several websites, including those sponsored by NIH and one interesting one, Quackwatch.com, are also beginning to offer resources for both providers and consumers.

Using state board exams as a carrot or stick to force attention to specific issues is often seen as an attractive option. This discussion is also accompanied often by a call to require accrediting bodies to assess this content in a given curriculum; however, it is unlikely that more than a cursory assessment of the knowledge base of the test taker is possible on any given specialized topic when a lengthy and comprehensive test is administered. Moreover, accreditation today is likely to focus more on outcomes than the process of the education.

One last thought should be part of any conversation about the use of complementary and alternative therapies. The growing interest in these by

consumers of health care is symptomatic of a concern that also should be addressed. Consumers turn to these therapies primarily because they do not believe in or trust in the ability of traditional forms of health care to resolve their health care needs. These consumers, already distrustful of the health care system, are highly unlikely to readily volunteer information about their use. Consequently, it is vitally important that health care providers have the ability to develop strong therapeutic relationships and have an ability to elicit truthful histories in their assessment of the consumer's health care practices and beliefs.

I would suspect that a whole bunch of us in this room already use alternative therapies or complementary therapies, and I wonder if we asked everyone who does that to raise their hand whether we would get an honest answer here.

This requires both good interpersonal skills, relationship building and a sensitivity to cultural diversity and beliefs. Without these, the provider is unable to elicit the information that will assist both individuals in the therapeutic relationship to reach

their health care goals.

In closing, we would therefore like to offer the following recommendations:

First, the establishment of an expanded database or databases on the range of complementary and alternative therapies and providers that are in use, the evidence that has emerged on these therapies and their efficacy, and a resource base for information and consultation;

The development of a generic curriculum for all health professionals on complementary and alternative therapies and the skills necessary to assess their use by patients and their families with a strong emphasis on the therapeutic relationship and interpersonal skill development;

Continued federal support for research to assess CAM therapies to develop the evidence base for practice;

A communication vehicle for health professionals to provide a consistent stream of information on these therapies;

A train-the-trainer initiative to provide

faculty and nursing or other health professions' education programs with the skill to teach the future clinician about these therapies;

A widespread continuing education intervention for the practicing nurse or other health professional;

And, a communication tool for the consumer of health care to provide accurate and timely information about the evidence available on complementary and alternative therapies.

Thank you for the opportunity to be here today, and I look forward to the conversation.

DR. GORDON: Thank you very much, and thank you also for being so precise and ending so beautifully, and for the recommendations.

DR. BEDNASH: Later on, I will tell you about my own complementary experiences.

DR. GORDON: Okay.

Neil Sampson.

MR. SAMPSON: Good morning, happy to be here. I wanted to have this opportunity to speak before this distinguished Commission on the role of the Health Resources and Services Administration, U.S. Department of

Health and Human Services and the Bureau of Health Profession in preparing tomorrow's health providers.

As you are all aware, demographics of this country are changing. In fact, within the next two years, the Hispanic population in America is expected to surpass the African-American population to become the most populous minority group. 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 U.S. population. In other words, we are fast becoming a majority of minorities.

With these changes in demographics, there comes a changing reliance in involvement and 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.

The increase among consumers is spurring a change in health education curriculum as schools strive to prepare their students. In fact, we have been told already that approximately half of the medical schools in

the country have courses or other educational activities in CAM. We have heard some of that discussion already.

However, we believe the inclusion or expansion of CAM should not be limited to the education for physicians alone. Rather, CAM therapies should be incorporated into the curriculum for all health professions disciplines. The current involvement of the Bureau in training and education programs on CAM is very limited. The Bureau's Division of Nursing currently funds three graduate programs that include content on complementary and alternative therapies, and the Bureau funds a 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 the financial assistance available to CAM students. The reason for this is simple, most of the Bureau's programs for health professions' development come through what is

referred to as Title 7 and 8 of the Public Service Act. Training and education programs are established through the specific legislation in the Public Health Service Act, and these programs are directed toward specific health disciplines.

As a result, we have very little leeway in how we allocate funds. In Fiscal 2000, the Bureau awarded 1,741 new and continuation grants. This year, we will invest some $350 million in training and education programs directed towards physicians, nurses, dentists, public health professionals and allied health professionals.

Where do we go? Should the Bureau be involved in training and education programs for CAM practitioners? We believe we should and for a number of reasons. First and foremost, to keep pace with the changes in the nation's health care system. It is imperative that providers are prepared to meet the challenges of the future. The federal government, through the Bureau, can play a leadership role by convening medical education leadership conferences, encouraging the development of standards of education, and positioning Titles 7 and 8 as

vehicles for faculty development 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 health and the well being of their patients.

While the knowledge about CAM is still developing and evolving, the Bureau believes that there should be a minimum level of post graduate education required for all non-allopathic and non-osteopathic physicians, which leads to state certification or licensure. 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 the public. To illustrate, there was just an article in Sunday's "San Francisco Chronicle," just this past week, that discussed a physician who was working for the past 20 years at community clinics treating poor patients, flew volunteer medical missionary missions to Mexico, and worked as the head physician at an L.A. clinic. The problem was is that he wasn't a physician. Over the years, he falsified his credentials and basically was practicing as a provider, and the result is you end up with requirements where we need stricter controls for credentialing and licensing activities.

Certainly, this isn't a CAM issue. The problem is that it does show the need for strong state licensing/certification requirements for public protection.

Finally, the structure of the work force, 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 delivery, cost and quality. Such efforts help identify problems and allow for policy makers, state and national leaders, health professionals, state providers and payers and consumers to determine issues, discuss strategies and consider appropriate actions.

The Bureau, through our National Center for Health Workforce Information, has held court in future meetings on health workforce issues. Through such research meetings, we can better assess the impact of health care workforce on health care delivery and determine where we go from here.

Unfortunately, we know that, once we get beyond physicians, nurses, dentists, pharmacists, our data are very limited. This is where professional associations, schools, licensing bodies can help. These groups can help collect the data we need to assess emerging CAM workforce issues. The Bureau's role in health professions' training and education is assuring that 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. We believe that tomorrow's health care providers must be prepared to meet the needs of their patients, and we are ready to meet those challenges.

Thank you very much.

DR. GORDON: Thank you very much.

Sara Collina.

MS. COLLINA: Good morning. I am Sara Collina. I am a senior policy analyst at the National Breast Cancer Coalition. On behalf of the Coalition, I want to thank you for this opportunity. We strongly support the goals of the Commission, and we appreciate this opportunity to contribute.

The National Breast Cancer Coalition is a grass roots organization made up of over 500 organizations and 60,000 individual members. Our goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research, to improve access to high quality health care and breast cancer clinical trials for all women, and to expand the influence of breast cancer advocates in all aspects of the breast cancer decision-

making process.

I will be addressing this issue in the context of quality health care because, ultimately, we think that that is what CAM and all other health care policies should be about, finding ways to describe, measure and provide quality health care for everyone.

So, what is quality care? Some focus on morbidity and mortality. Others describe it by what it isn't, too much, too little or the wrong care. These approaches lack a patient perspective. We need the right care at the right time, but the right care can be a very personal choice. Two reasonable patients with the same diagnosis may chose very different treatments.

On the other hand, quality care is not simply personal taste or a popularity contest among doctors. Of course, we want to avoid rude doctors and long waits, but we can get free parking, sparkling water in the waiting room, a long relaxed visit with our provider and leave with the wrong diagnosis.

The National Breast Cancer Coalition has a different approach. We think of quality breast cancer care as six core values: access, information, choice,

respect, accountability and improvement. We are publishing a guide to quality care based on these values, and we will be happy to share it with you. Briefly, the goal of the guide is to give breast cancer patients a different and better way of thinking about quality care. We want to move away from a "doctor knows best" mentality and equally damaging "more care is better care" approach. Instead, we ask patients to take some time to learn about breast cancer care and become their own advocates.

The guide is our best advice. It is what we tell our family and friends about breast cancer care. We explain the value of medical evidence, how doctors do and do not use it, and how it should be used. We describe what clinical guidelines are and how to find them. We explain the difference between absolute and relative risk. We discuss why a second opinion should be from a doctor outside the institution of the first doctor. We describe the laws regarding medical confidentiality and laws requiring coverage of certain procedures. We advise bringing a tape recorder to doctor appointments. We describe what coordinated care is and what should be covered in a comprehensive treatment plan.