These are just a few examples to give you a sense of our values and how we approach the issue of education and training of CAM practitioners.

The National Breast Cancer Coalition believes that both the medical community and patients should approach CAM with an open but critical mind, exactly as they should approach conventional care. The same questions apply: What are the risks? What are the benefits? How strong is the evidence that answers these questions?

The two categories of CAM versus conventional medicine are really not helpful to patients. The categories themselves encourage the misperceptions; that conventional medicine is all based on evidence, it is not; and that CAM therapies are natural and therefore harmless, obviously untrue.

Many conventional providers are justifiably angry and worried that patients are being tricked into wasting precious resources on dangerous and ineffective CAM treatments, but many have yet to learn about effective CAM treatments. For example, an oncologist may have no idea that acupuncture can alleviate nausea

associated with certain cancer treatments. This "Us-Them" mentality about CAM has serious consequences because many conventional health care providers know so little about CAM therapies they fail to discuss it with their patients. Patients respond by lying or withholding information and then end up weighing the potential risks and benefits of CAM therapies on their own.

The medical community needs to stop thinking in two categories and, instead, focus on developing better systems for creating and weighing evidence that can tell us what we really need to know, what does and does not work. Allow me to use the Quality Care Values to describe in more detail our vision of CAM education.

Information. Patients need accurate and complete information in order to make good decisions. They need a clear and complete presentation of all conventional medical options, along with what is and is not known about how well they work and what harm they can do. The patients need the exact same evidence-based information for CAM, and they need it at the same time and place that they receive information about conventional treatment options.

Choice. Guided by accurate information, patients should be able to chose among therapies that offer some benefit. Patients should also be told about all clinical trials that are relevant to them. CAM that has some evidence of efficacy must be part of the range of choices presented to patients. Relevant CAM clinical trials need to be presented to all patients as a reasonable health care option.

Respect. Providers need to treat the patient as a whole person rather than a disease or a body part. For example, discomfort and anxiety need to be taken seriously. They are a real and powerful part of breast cancer and many other health care experiences. They can also often be alleviated. All care providers should have a basic knowledge of CAM and provide an overview to patients. They should also respectfully encourage patients to be honest about their interest in or use of CAM.

Accountability. Patients need competent providers with credentials that mean something to patients. The system should be easy to understand and transparent so that everyone can easily learn what a

credential or license means, but credentials by themselves do not create accountability.

It is a clear and accessible appeals process that protects patients. Any licensing or credentialing process must include a convenient and effective way for patients to appeal or complain, and there must be meaningful consequences. This is true for both CAM and conventional practitioners.

Access. Breast cancer patients should have access to interventions that have been shown to help. All providers should either provide or refer patients to CAM therapies that have been shown to have some efficacy. Health insurers and plans should have an evidence-based approach to coverage and educate patients about CAM.

Improvement. We want a health care system that is continually learning from patient care. We need more and better evidence about both conventional breast cancer care and CAM. NBCC believes that CAM research has been extremely underfunded. A large investment in this kind of research can not only bring great health benefits to patients, but in the long run could provide savings in health care costs. Right now, breast cancer trials

consist mostly of drug companies exploring slightly different ways of using their patented drugs or slightly different combinations of existing drugs. We need a different focus, and CAM research is fertile ground for innovative questions about breast cancer.

We also need to expand our notion of health services research. We need to be measuring what matters, not just morbidity or mortality and not just a handful of quality of life measures. CAM research often requires innovative design which may help expand what we measure and how.

The federal government needs to fund not only CAM research, but also CAM education for all the players: patients, health care providers, employees and third-party players. There is so much misinformation and mistrust around this issue a major educational effort by the federal government could go a long way in dispelling myths and getting effective treatments to patients. NBCC strongly supports increased funding for more and better research to find out what CAM therapies are effective. We also strongly support a federal educational initiative on CAM and evidence-based medicine.

CAM practitioners certainly need consistent and educational standards and accountability within the licensing and credentialing process, but this by itself would do little to help women get the care they need. We believe that patients will be better able to chose the right provider, CAM or otherwise, when there are national standards for health care, standards that are comprehensive, evidence-based, updated regularly and accessible to everyone.

These guidelines should not be broken into conventional versus CAM, but rather include the entire range of care options. Guidelines can't tell anyone what their treatment should be, but they can provide an invaluable overview of what we have learned from medical research so far. Patients will and should continue to make very different choices about health care, but one national trustworthy source for evidence-based health care information would provide a powerful tool for patients and their loved ones who are trying to get quality care. It would also highlight what research questions remain.

From patient perspective, it is not either

conventional or CAM but what actually helps that matters. Health care policy needs to reflect this view. CAM should be completely incorporated into all aspects of health care policy.

Thank you for this opportunity. We believe that breast cancer advocates and patient advocates have an important role to play in the development of CAM policy, and we look forward to working with you in the future.

DR. GORDON: Thank you very much and thank you for the recommendations, as well.

Questions. Joe.

Panel Discussion

DR. PIZZORNO: This is directed to Mr. Sampson. As Dr. Orzack stated I think so eloquently earlier this morning, for a profession to become distinct it needs to establish educational and practice standards, and those educational and practice standards must evolve over time.

At what point does the profession come under the purview of your organization and, once it does come under your purview, what impact can you have on those emerging professions?

MR. SAMPSON: Generally, the way they are recognized is, first, almost all of them have to be accredited. That means the Department of Education is the first area that gets approached for accreditation, the accrediting body which has to be separate from the professional body. They have to then show that they have a series of information, science, et cetera, in order to get accredited.

So that then sets up the base. The next piece is then specific legislation which allows that emerging profession to be included in the coverage of the Acts, so they then have to get specifically mentioned. That is really the only way that they are done.

The second part of the question is the degree of involvement. Most of the involvement we have would not be so much in the emerging profession, it is to assist them. It depends on how the law is structured, what Congress says that we are willing to use monies for to do this. Most typically, they are the kinds of things that were developed or mentioned here. Once these are accredited and licensed and standardized, then the issue would be curriculum development, faculty development and

to some degree student support. Those would be the kinds of issues.

DR. GORDON: Effie.

DR. CHOW: Thank you very much for your presentations. I am glad to see a nurse on board here because being that there are so many nurses that have been underrepresented. So I am very happy to see that.

Many of you mentioned about evidence based. In fact, for the last panel, very strongly so, and this panel. Then, you also talked about culturally sensitive and looking at cultures. Then, the next comment is that it should be evidence based before practiced. What does that mean in terms of looking at practices that has been successful within the culture, but because there has been no money and it is new to this Western civilization that it isn't "evidence-based" from the way we research biomedical?

Are you talking about absolute controlled studies and squeezing it into a box, et cetera? Could you make comments on that. And should there be practice if it has been proven that it is used in the cultures successfully?

DR. FISHMAN: Can I take a crack at that?

DR. GORDON: Sure.

DR. FISHMAN: One of the big problems I think that we face is that, when we talk about CAM, we are talking about such a span of activities that some are potentially threatening. For example, acupuncture and asthma, I have had some experience with that. You have to take it into account. You have to be very good at what you are doing.

On the other hand, there is music therapy and there are other therapies where if you listen to a radio while studying that is music therapy in a way.

So, therefore, we have not been circumspect in breaking it down modality by modality. There is a big difference, also, in what I as a practitioner in my office can do and what I as a professor of medicine put in the book to teach medical students. For example, I can have you come in, make believe you are a patient, and you say, "I have been taking this medication. It is good." I say, fine, that is great. Evidence is there.

On the other hand, if you come in to me and you say, "Should I take this?" I will say, well, you better

be careful now because you are taking phytoestrogens, you are taking this, you are taking that. Or, I can go further and say, uh-uh, you really can't do that.

So one of the big problems that we have faced in dealing with your question is do we break down CAM into modality-by-modality and treat it that way? And the second is, what do you want the money for? Do you want the money to investigate whether a cultural activity such as acupuncture -- the way we do it is not in the context of the framework that everybody does who really knows acupuncture in China. For example, I visited China, it is a whole scheme of things. Over here, it is like one thing. Or, we will do tai chi, and it becomes a part of physical therapy.

So the question is, how do we sort out CAM? A very critical point. What do we want? What warrants research? What warrants money?

On the other hand, why don't we just take the evidence that, look, this thing works, it is harmless. We will keep looking, but if we can prove it, yes, use it.

MS. COLLINA: If I could add that this issue of

squeezing it in a box is interesting to me because we have struggled with this.

Obviously, as a breast cancer organization, there is a lot of unanswered questions. It seems to me that we need answers and we want answers and we want some way, a design of some sort of trials and some way of systematically exploring what works and what doesn't.

To the extent that the box is a problem, we need to change the shape. We need to look at that. We need to rethink what we mean by a clinical trial, what we mean by evidence. It doesn't mean that we give up the basic core aspects of evidence-based medicine, but I think there are more creative ways of looking at it.

I don't know if I am following up here or not, but I would say that that is exactly where the funding should be focused until we answer that question. Too often in conventional medicine, things have come into the system because we don't really know but people are interested in having it, and then we learn later that it doesn't work.

So I think that is a perfect example that that is where the focus should be, and the focus should be in

looking for new and creative ways of measuring.

DR. BEDNASH: Just another piece of this, I think there is a difference between developing a bond and a partnership with the person in that therapeutic relationship, so that you have a sensitivity to their own cultural beliefs and views about what is helpful and what gets them through the experience that they are having.

I can tell you that when my father had his bypass surgery and ended up developing shingles afterwards and said he would rather have another bypass and have his chest split open again than to have to go through the shingles experience, it was so terrible. None of the traditional therapies and medications he was given helped.

His brother-in-law, who is from Mexico, drove in and picked him up, and took him to a provider in Mexico who gave him an injection. I think, as far as I can tell, it was a Vitamin B injection. My father came home and was cured.

Now, I think we don't understand the placebo effect, you are absolutely correct, but we also don't understand the power of the cultural beliefs. We are

Latinos. What my father believed was going to be helpful to him was helpful to him.

So there is this partnership. It may not be that I, as a more traditionally oriented provider, would suggest that he go and get this, but I need to understand how it does relate to him or someone else in their seeking some kind of relief or some kind of ability to control this health care experience.

So it is a partnership. Above all, I think we need to be concerned about not creating harm or intervening when there is the potential for harm. Sometimes, the only way we can do that is through some base of knowledge that comes from the more traditional evidence-based protocols to give us that comfort level.

MS. CHOW: Thank you very much. I do want to know, how many are practicing alternative medicine?

[Laughter.]

DR. GORDON: Wayne, and then Charlotte.

DR. JONAS: I can't decide between communication and evidence, so I am going to defer to Charlotte for her question.

SISTER KERR: Assuming we can define food,

would you say that real food for real people is a complementary alternative medicine? Specifically, I was thinking to start with Sara.

MS. COLLINA: I think that is a perfect example of what is wrong with the category. I mean, that category means nothing to me. I couldn't even tell you right now as a patient which things that I am doing you would consider to be complementary or alternative. Because there is very little profit in food research and nutrition research, it has been underresearched. And so, in that way, it is like many complementary interventions. At the same time, there is clear biological -- I mean, there is very little controversy in the medical community that it impacts health. So I think that is the perfect example of what is wrong with the category.

SISTER KERR: And when you answer, if anyone else does, is there something we need to say about that in policy?

MS. COLLINA: Well, I guess I will just jump in here and say this is why I think that, to the extent that we can give up the label -- and I realize that that perhaps feels like a big task, but from where I sit that

doesn't feel like a big task. People don't look for complementary and alternative medicines. They look for things that will help them. That is the only question people are asking.

So, like I said, I think the categories themselves are very limiting, and not only does it create stigmas and confusion about CAM, but it creates a lot of dangerous myths about what conventional medicine is and is not.

DR. BEDNASH: I would like to also come in here, too, because I think I agree with you in what you are saying, Sara.

I am very concerned about the power of language and what language conveys and more concerned -- not to be offensive to my colleagues in other fields but to be concerned about the use of the term "medicine" as the baseline here. Because medicine is medical practice and medical practice does not represent the full range of health care and health care professionals today.

I worry about medicine and a focus on that as a baseline against which all others are measured, rather than the notion, as all of us are aware, that health care

is provided by a variety of individuals, a variety of professionals, who have a scientific base for their practice, and some of what are considered complementary providers have a scientific base and they are not alternatives to medicine they are in fact team members and partners in the process.

I would strongly encourage us to think about complementary and alternative health care practices, although sometimes it is hard to figure out what is alternative and what is not depending on where you sit in your life, in your culture, in your beliefs. So I think language is very important and it is very harmful in its process. Anything that can be done to change that would be very useful.

SISTER KERR: I noticed when you presented you said "complementary and alternative medicine and therapies." It really hit me right between the eyes there. Thank you.

DR. BEDNASH: I thought about dropping "medicine," but you are the Commission on Complementary and Alternative Medicine, and I think it is complementary and alternative health care practices and policies for

those. It is not medicine only.

I am very concerned that there is a strong emphasis in today's conversations about medicine and medical practice and medical education and medical certification and examination. There is a National Council of State Boards of Nursing. I am sure there are councils for the licensure of a whole range of professionals that ought to be in this dialogue because you want to influence them as much as they want to influence you.

DR. GORDON: I would like to make one point. We agree that there has been more of a focus on medicine. In the solicitation of recommendations and considerations, we consulted all the professions, including a number of different nursing organizations. Your point is well taken. We used medicine as one example, just as a little bit later on we are going to use acupuncture and Chinese medicine as an example of a so-called CAM approach.

I had a question for Mr. Sampson. I really appreciated your remarks and I am wondering what you would have us do, what you would like us to do to support

you in helping to encourage training both in this more holistic approach and in specific CAM modalities, and also for CAM practitioners? You indicated an interest in encouraging this to happen.

What can we do as a Commission? What kind of recommendations would you like to see from us?

MR. SAMPSON: You have broken down -- I mean, in terms of health professions, there are two parts. One part is conventional, the conventional practitioners and their need for information on complementary and alternative therapy and how they can be used and which ones are effective, just some information on what is occurring in various cultures and populations. That is essential because you can't treat an individual without knowing basically the whole person, and you need to know what can help and also what they are doing so that you can work as a part of that.

So that has to do with faculty development for all of the professions. It has to do with, again, curriculum reform and the integration of research findings when we do find information out into practice. We do have some programs that do that. Their primary job

is to take the findings from such places as ARC or NIH or FDA or others and try to put them into practice as to how they would. Because, remember, any individual that comes out of a health professions program today has what a 30-, 40-year career ahead of them. So you want to influence the next three or four decades, that is where most of the practitioners are.

So that is one set of issues, make sure that we can provide information to current practitioners, to get faculty development and faculty mentors going and that kind of activity for the existing health professions.

The other side is for those practitioners, we can refer to CAM practitioners, there is a different problem. That one is, as we sort of describe the issue: One, there has to be an acceptance by the public. I mean, that is really where all these are going to start occurring and where they are going to grow. Then, the profession itself has to come together, has to get a core set of knowledge, has to start standardizing its approach to treatment, has to deal with the 50 state -- or 56 depending on how many you want to call -- the state licensing procedures, the accrediting requirements, and

the universities and colleges and the whole educational and academic infrastructure that is going to support them, et cetera. So that all has to occur.

Then, there has to be an issue where there is specific legislation that says these kinds of practitioners -- and names them -- will be available for these range of things, which for the profession itself would include curriculum, faculty support, perhaps the support for students and a whole host of issues that are similar for the kinds of programs that support medicine, nursing, dentistry, et cetera, et cetera.

DR. GORDON: I am wondering if also one of the issues that we have heard about many times is many practitioners, both conventional and CAM -- or CAT, I suppose might be a better term, I kind of like that -- CAT pratitioners, want continuing education. I am wondering if the Bureau, as a possibility, might be interested in supporting some of the efforts at continuing education for this whole spectrum of practitioners.

MR. SAMPSON: When I started out, I said primarily taking information and putting it into

practitioners, you know, those community-based programs working with the local professional groups at perhaps the nursing associations, state medical societies, local medical societies, the CE.

Yes, we do a number of those activities. What is occurring today in practice for a lot of us is that we still have individual practitioners, but more and more people are coming together in teams and working in groups. They are finding that that is really the best way to deal with the patient population. That is one of the critical bases for understanding not only the therapies but who the practitioners are. If you don't work with them, you don't understand what they can offer, how they can provide.

If one doesn't work with a social worker as a case manager for a very complex geriatric case, then the nurse or the physician or others don't understand how valuable that social worker is in making sure that the treatment plan, the therapeutic plan, can actually occur. You know, if you just send a very complex elderly patient home without knowing what is going to occur and what the home setting is, the likelihood of that individual really

being able to benefit is limited.

That is where these kinds of activities -- we have found that in a number of different ways. So, an appreciation of the other practitioners is important, a kind of inter-disciplinary training. Continuing education is also where it can work, but sometimes that is difficult to do. The kind of continuing education we have today we are not quite sure, frankly, it is very effective.

So, while it is a wonderful idea, we haven't really found the necessarily best mechanism to assure that lifelong learning, which is really what CE is supposed to be, is actually occurring as opposed to, you know, a nice cruise where we go and do a little course work in the morning and then we can spend the rest of the day playing golf or something.

DR. GORDON: Would you be interested in some recommendations about effective continuing education from us?

MR. SAMPSON: That is exactly what we would be interested in. That, and as I said what we need also is then the authority to act. We are somewhat restricted.

Certainly, one way to start is in the interdisciplinary part. That is not easily done in most of the academic institutions. Academic institutions, if they are training particular health professionals, they stick to their own. Pharmacy school, it is tough for them to break out.

We are trying to look at ways that -- you know, we think anatomy is the same for a physician or really a nurse or a pharmacist or another practitioner. You know, the body doesn't change that much. But that doesn't occur. And, yet, if people work together, there is an opportunity to do that.

So we would suggest that one of the things that you might want to consider is how interdisciplinary education would be very valuable.

DR. GORDON: Great. Thank you.

Do you have a quick question, Wayne? We are just about out of time.

DR. JONAS: Very briefly, I just wanted to know, Ms. Collina, has the National Breast Cancer Coalition kind of taken the next step, it seems to me the next obvious step, and that is how to really integrate

patient perspective into the development of this better system of evidence-based medicine that you have described which I think is a broader system than what we currently have in terms of better research?

Because these are value issues, and it is not simple just to have a panel of lay people or patients who then sit on a few advisory boards. Have you thought about actual mechanisms as to how patient values can be injected into the research system and into the evidence-based decisions that are made?

MS. COLLINA: That is a good question. Well, I will tell one story. We have been integral in founding a very innovative research program as part of the Department of Defense. We were looking to dramatically increase breast cancer research funding, and we were told that there was a firewall, that there was absolutely nothing we could do about the fact that this money was on this side and this money was civilian.

So we just jumped over the wall and said, all right, then let's have a war against breast cancer. We would like to have this amount of money spent on innovative ways of thinking about breast cancer. And we

have, through that -- I wish I had the numbers here because it would be very interesting. We, the taxpayers, all of us, have funded a dramatically impressive new -- many, many new different kinds of ways of thinking about breast cancer research and some of them have included some CAM.

Although, what I would be interested in hearing from you all is ways that we could even expand that. For example, though, there are a number of ways in which breast cancer advocate involvement is integral to that. Every single panel, including the scientific peer review process, includes a trained advocate. So I think that is a model.

DR. JONAS: Do you have a training program then?

MS. COLLINA: Yes, we do. We have a science course for breast cancer activists.

DR. JONAS: So that they know how to communicate and interact in those various groups?

MS. COLLINA: We have. I know all about this. Yes. We now have over 1,000 breast cancer activists who have graduated from Project Lead, our science course for

breast cancer activists. It is a very intense course. It starts about 7:00 in the morning, ends about 10:00 at night. It is five days.

Anybody who is interested, any breast cancer survivors out there who would like to have the tools of science to be able to dialogue effectively with the scientific and medical community and also just become a better advocate, has gone through this process. It is a free program. We do it four times a year across the country. We will be doing it in Europe next year. It has provided us an opportunity to become educated.

DR. JONAS: Can we get information about it?

MS. COLLINA: Absolutely.

Are we done? Because I want to try to answer a question that came up before which is this issue of -- it seemed like it was laid out as a very difficult question, the issue of should practitioners incorporate CAM into their practice or should they refer others. Was that the question or was there some question about whether that was a sort of a tricky thing, whether people should be doing the acupuncture or referring the acupuncture.

If I heard that question right, that doesn't

seem, from where I sit at least, to be a very complicated question. I mean, from a patient's perspective, the issue is that the care is coordinated and that it is convenient and that it is respectful. So I don't care if I go to my -- I mean, certainly with breast cancer we are used to having a team. I don't need my surgeon to be able to do acupuncture. I just need my surgeon to understand that they are a part of a team, and this issue of interdisciplinary rises right to the surface here.

What I need is for a team of people to understand how they all relate to each other, to communicate. And I need one person, not me, to be able to coordinate all aspects of my care. I guess it doesn't matter to me, from where I sit, whether one person -- I don't need one person to do it all.

DR. GORDON: Great. Thank you. Thank you all.

We are going to take a 15 minute break, then we will resume.

[Recess.]

MS. CHANG: If the following speakers would please come up to desk: Dr. Joseph Helms, Dr. Lixing Lao, Mark Blumenthal, please.

Plenary Session II: Continuing CAM Education and Training

DR. GORDON: We are going to begin the next panel now, and the first speaker will be Dr. Joseph Helms.

Welcome.

DR. HELMS: Mr. Chairman, members of the Commission, I have been involved in physician acupuncture education since 1977. During this quarter century, the discipline of medical acupuncture has emerged and defined itself, creating its training guidelines, establishing its practice standards and regulating its credentialing requirements. I am pleased to review its history and its current status for the Commissioners and for the public.

It is necessary to clarify that I address only the discipline of medical acupuncture. That is, acupuncture as taught to and practiced by physicians who are licensed in conventional, allopathic and osteopathic medicine. I do not address other disciplines of acupuncture that are taught or practiced by credentialed non-physicians in this country.

M.D. and D.O. physicians come to acupuncture

already fully qualified in Western biomedical science and practice. Having spent over 4,000 hours in their formal training programs, they are experienced as health care providers and are embracing it as an additional discipline to integrate into their practices. Most physicians limit their acupuncture practice to 25 percent or less of their professional activity.

In 1980, the first comprehensive medical acupuncture training program in the United States was sponsored by the American Holistic Medical Association, as one of its core training modules. It was accredited for 200 hours of continuing medical education and was the forerunner of the Medical Acupuncture For Physicians Program which has been sponsored since 1983 by the Office of Continuing Medical Education of the UCLA School of Medicine.

From its beginning, the Medical Acupuncture Program has been enthusiastically received by physicians and spread quickly by word of mouth and favorable coverage in conventional medical newspapers and meetings. Because medical acupuncture is an unusual discipline in medicine, one that requires the student to think and

perceive in non-conventional ways, the teaching of the discipline must be clear and rigorous.

The content and organization of the curriculum and the standards of the knowledge base and clinical skills required of the didactic and clinical teachers in the UCLA program have surpassed all criteria expected for compliance with the Association of Teachers of Family Medicine and the Accreditation Council for Continuing Medical Education.

The early professional challenges faced by graduates of Medical Acupuncture Programs involved recognition by conventional medical bodies such as third-party payers, liability insurance providers, hospital staff privileges, academic status and state medical boards.

To address these and other challenges, in 1987, graduates of the AHMA and UCLA programs created the American Academy of Medical Acupuncture to represent the professional interests of well-trained physician acupuncturists. Entry membership requirements were established as 200 hours of formal training. Full membership requires an additional 20 hours of training.

The formal training of 220 hours was adopted in 1987 by the World Federation of Acupuncture and Moxibustion Societies which is a World Health Organization-sponsored entity, as a requirement for physicians training in its member societies, consistent with the full membership requirements in the American Academy of Medical Acupuncture.

In this country, as individual states created training guidelines for physicians, 200 hours was the amount of formal training uniformly adopted as necessary to develop safe and effective practice skills. The UCLA program and that of the New York University College of Medicine and Dentistry, which are the two major resources for physicians acupuncture education in the United States, maintained their training programs to conform with these standards.

The 200-hour criteria is considered to be the minimum formal didactic and clinical training to prepare a physician to safely and effectively practice medical acupuncture. It is the equivalent of completing training through the first year of medical residency. Like practicing all medical specialties, practicing medical

acupuncture is a lifelong open book examination. Physicians are encouraged to work with study groups, regional chapters of the AAMA, and the national symposia of the AAMA, to broaden and deepen their knowledge base and clinical skills.

The AAMA requires an additional 20 hours of CME in acupuncture for full membership and 50 hours every three years for membership renewal. The American Board of Medical Acupuncture requires 300 hours of formal training for qualification.

Since 1984, there have been numerous meetings of physicians from Western countries to discuss the standards of physician training and practice of acupuncture. These have been sponsored by national medical acupuncture societies in the United States, Canada, Australia, Sweden, Germany, Belgium and France, and have served as the forum for cross-fertilization and standardization.

Several enduring international societies, the Pan Pacific Forum on Medical Acupuncture for the Pacific Rim Countries and the International Council of Medical Acupuncture and Related Therapies for European countries,

have developed from these meetings and continue to serve educational needs and international exchange of the member countries. The common denominator in the national and international societies is integrating Western biomedical training with traditional theory and practice of acupuncture.

In 1996, the World Health Organization's Division of Traditional Medicine convened an international assembly that voted on training guidelines for different levels of acupuncture practitioners. This document was approved by the World Health Assembly and has been distributed to member nations.

Qualified physician graduates from schools of Western biomedicine who wish to include acupuncture as a technique in their clinical work are recommended to have not less than 200 hours of formal training. This training should include the history and cultural context of acupuncture, the basic theory of acupuncture and Chinese medicine, knowledge of the acupuncture points, traditional methods of diagnosis and the principles and techniques of acupuncture treatment.

The document acknowledges that qualified

Western physicians already know medical theory, diagnosis, safe practice techniques and practice management, and that their use of acupuncture will address problems they commonly treat in their medical specialties. The WHO training guidelines embodied that which has been recommended and practiced in Western countries for 10 to 15 years. The regulations have been well established in all European and Pacific Rim countries and are time tested in the United States. They provide a matrix in which each training program can provide its physician students with an education in acupuncture that results in substantial theoretical understanding of the discipline and a responsible and effective technique for its execution in clinical practice.

Public safety is well protected by the current standards of training and regulation. In the United States, the American Academy of Medical Acupuncture recommends that individual state medical boards require the 200-hour minimum formal training for physicians to register as medical acupuncturists. Currently, all states except three that require physician registration

follow the 200-hour standard. Most state medical boards, however, are disinclined to regulate or certify physicians in medical acupuncture. They argue that the discipline is included in the scope of practice of medicine and does not need additional registration.

In the practice of medicine, it is the hospital staff privilege and liability insurance guidelines that document quality of training. AAMA membership eligibility is the gold standard in every state for practice privileges and insurance coverage. The AAMA serves the profession and the public by establishing minimum training and practice standards for membership, offering continuing education in medical acupuncture, recommending practice privileges and liability insurance qualifications, encouraging regulation by state medical boards and by disseminating reliable information about the discipline to the public.

The American Board of Medical Acupuncture, a sister society to the AAMA, offers a certification process in medical acupuncture that requires documentation of acupuncture practice and results and passing an examination. Because the majority of

physicians practicing acupuncture in the United States are graduates of the UCLA Medical Acupuncture for Physicians program, the majority of physicians in the AAMA are UCLA graduates. Membership is not limited to UCLA graduates, rather members come from all schools and disciplines of acupuncture taught in the country.

Given the wide public acceptance of acupuncture and the broad appeal of the discipline to physicians, it seems reasonable to organize exposure programs for physicians in training as well as physicians in practice. There is certainly a strong interest among medical students, residents and fellows in acupuncture and other CAM disciplines. Exposure programs are being tested in medical schools around the country and some specialty programs such as anesthesiology, pain medicine and osteopathic manipulative medicine require exposure to acupuncture.

Programs for medical students of as little as one or two hours provide useful information and orientation to the phenomenon of medical acupuncture. Half-day or full-day programs for residents and fellows can give an experience of the technique and an

understanding of its role when integrated into practice.

In conclusion, with respect to the training and education, credentialing and licensing of physicians practicing medical acupuncture, I contend that the discipline has defined and regulated itself and a standard in a fashion that is acceptable by national and international standards.

Furthermore, the medical acupuncture training and credentialing infrastructure has shown, through 25 years, to be reliable for these physicians, and safe for their patients. I consider medical acupuncture to be a mature and effective discipline with a responsible training, credentialing and accountability system, and recommend that it be endorsed by the Commission in its current form.

I strongly recommend that exposure programs for medical students, residents, fellows and practicing physicians be encouraged in all specialties of medicine. Such an education exposure will inform them of the value of medical acupuncture, how to refer appropriate patients for treatment and the recommended format and content-responsible training. Thorough basic training and

follow-through programs also should be made more readily accessible through conventional CME vehicles.

Thank you very much for inviting me to offer this presentation to the Commission.

DR. GORDON: Thank you.

Lixing Lao.

DR. LAO: Good morning, and thank you for the opportunity to speak here today. My name is Dr. Lixing Lao. I studied traditional Chinese medicine, known as TCM, and acupuncture at the Shanghai University of Traditional Chinese Medicine, and have practiced acupuncture and TCM for more than 18 years.

Many of you may know me as a researcher because of my work at the University of Maryland where I conduct clinical trials on the efficacy of acupuncture. I was the principle investigator on acupuncture research for postoperative pain after dental surgery which was one of two uses of acupuncture which received the full endorsement by NIH at their 1997 consensus conference.

I come to you today, however, to talk about education, training, licensure and certification of acupuncturists in this country. Ten years ago, along

with some very dedicated and esteemed colleagues, I founded the Maryland Institute of Traditional Chinese Medicine, a school that is accredited by Accreditation Commission for Acupuncture and Oriental Medicine, known as ACAOM, and is a representative of acupuncture schools that prepare students to become certified by the National Certification Commission for Acupuncture and Oriental Medicine.

I currently teach and serve a board member and clinical director of the school, and the comments I am about to make reflect my experience in this capacity, as well as from my experience as a former board member of the Maryland State Board of Acupuncture which regulates acupuncture licensing for the State of Maryland, and as a site visitor for ACAOM which is the nationally recognized accrediting agency in the United States for the quality of education and training in the field.

First, I would like to talk about the training of professional acupuncturists. Accredited schools provide a minimum of three years of acupuncture training program, more than 2,000 hours, with at least 500 hours of clinical training and 360 hours of training in Western

medicine, and a full year of acupuncture and oriental medicine training program. The Western medical component focuses mostly on training acupuncturists to recognize signs and symptoms indicating that the patient should be referred to another practitioner, such as a physician, and also trains students on how to effectively communicate and interact with the conventional medical system.

This is similar to other health care professional, such as chiropractors, psychologists, and even physicians who are trained to work with the medical system and refer patients when necessary to another type of provider. This is emphasized throughout acupuncture training, even though it is more common for a patient to come to us after they have already pursued treatment by a conventional health care provider.

This typical three- to four-year training program is comparable with the number of training hours that are required by other health professions, and is considered to be a minimal amount of time required for understanding the richness and complexity of a medical system that has been under development for at least three

thousand years.

Acupuncture and TCM is a medical system not just a collection of points on the body and, like modern Western medicine, it takes years of study and practice to achieve competency and lifetime of learning to achieve mastery. Acupuncture schools provide extensive training meridian theory, diagnostic methods, tongue diagnosis, pulse diagnosis, differentiation of Chinese medicine, accurate acupuncture point locations, various acupuncture needling techniques, principle about treatment, dynamics of acupuncture formulas for point combinations and dynamics of Chinese herbal formulas which is not unlike the combination of different drugs that, when taken together, have an effect far different from the individual components.

Perhaps the most important part of the training, however, is extensive clinical training that the students receive. Like a doctor fresh out of medical school, it is not until one gets some clinical experience that all the information and theory starts to come together in a practical way. In our school, following ACAOM's high standards, the student begins by spending

150 hours doing clinical observation, and then 500 hours where they must provide at least 250 treatments to at least 30 patients before they can graduate. Each case is discussed with a clinical supervisor, most of whom have been trained in China and have many years of practical experience.

Traditional Chinese medicine is a completely different way of looking at health and illness, as compared to Western medicine. While the bodily organs such as liver, spleen, heart, lung and kidney are the same, their function in the Chinese medicine is very different than their function in Western medicine. Therefore, someone presenting with asthma may be diagnosed with a kidney yin deficiency, and someone with irregular menstrual cycles may have liver qi stagnation. Obviously, training in Western medicine diagnosis has very little overlap with Chinese medicine. Traditional Chinese medicine in acupuncture often provide fundamental health care for the patient rather than just symptom relief.

Why I make these points to illustrate the contrast between the 2000 hours high standard acupuncture

training as compared to fewer hours of training in some other health professions? I believe that it is a very positive phenomenon that more and more physicians are learning about acupuncture and chose to use it as part of the treatment options they have in their profession. When they incorporate this modality into their practice, it can significantly benefit and improve patient care, especially for temporary relief of some symptoms and simple illnesses.

However, just like a family physician would recognize the limitations by referring patients with a cardiovascular disorder to a cardiologist, a health care professional with minimum training should recognize limits when treating patients with a complicated, chronic condition that requires comprehensive treatment by a professional acupuncturist.

I must take issue that in some states even a fully trained professional acupuncturists is required to practice under the supervision of some other types of health care providers. It is incomprehensible to me how a physician, for example, with little or no training in acupuncture can be legally authorized to supervise a

licensed acupuncturist. This is like requiring an electrician to supervisor a plumber. Knowledge of one field does not automatically confer knowledge of the other field, and it does nothing to assure the competency of the practitioner.

This is a public safety issue. I urge the Commission to consider this issue and be fully aware of the different levels of training and scope of practice among health professionals. People seeking acupuncture are unlikely to understand the difference in training among different types of practitioners.

In addition to accreditation standards, national certification is one of the few ways that the public can determine the level of training of a practitioner. Just like every medical doctor is required to take a board examination, most states require acupuncture practitioner to pass the national examination offered by the National Certification Commission for Acupuncture and Oriental Medicine in order to be eligible for an acupuncture license. The passage of a national examination ensures that the practitioner has the basic knowledge of acupuncture and TCM required for an entry

level acupuncture practitioner.

Another reason that is very important for the Commission to look at the education, training, licensure and certification is for reimbursement. More and more insurance companies are beginning to cover acupuncture, although with many limitations and restrictions. I sincerely hope that in the near future all government health care programs, such as Medicare, Medicaid and the military, include acupuncture in their health care program. Some of these programs do not even offer acupuncture or only offer it if performed by a physician.

To assure high quality of practitioners, I hope that the Commission will recommend that licensed acupuncturists be part of the health care team to help to facilitate that to happen.

As acupuncture and TCM become more and more incorporated into mainstream medical systems, it is important that acupuncture practitioners and medical doctors work together rather than competing with each other to deliver the best health care for the patients. In the University of Maryland medical system where I work, physicians, medical acupuncturists, professional

acupuncturists work together as a team referring patients to each other as appropriate. Our patients are very satisfied with the health care we have been delivering in this system. I truly believe that this should be an ideal model for the health care system in this country.

In summary, I would like to ask this Commission to recognize that acupuncture is a comprehensive medical system that requires extensive training to be fully and correctly practiced. The national standards for accreditation of acupuncture schools assure high quality and comprehensive training program and a national exam, such as NCCAOM examination, for certification of acupuncturists assures that the practitioners have a basic level of knowledge necessary for high quality care. These are gold standards for all health professionals and are important tools to protect the public from untrained and unqualified providers.

Other health professionals should have a basic understanding of acupuncture as a different approach to healing that can complement conventional treatment and be encouraged to include acupuncture as part of health care options for their patients.

Health care reimbursement should be made available to patients receiving treatment of acupuncture and Oriental medicine.

Finally, I would like to mention that the American Association of Oriental Medicine and the National Acupuncture and Oriental Medicine Alliance have read these remarks and fully concur with these recommendations.

Thank you very much, and I will be happy to answer any questions. Thank you.

DR. GORDON: Thank you, Dr. Lao. One of the things that I want to mention, just for you as well as for other speakers, is we very much appreciate efforts of organizations to come together to make recommendations together. In a sense, one part of our effort is to encourage that in the fields. So, thank you for that.

Mark Blumenthal.

MR. BLUMENTHAL: Thank you.

I am from Austin Texas. Thank you for inviting me back to speak. I am grateful for the invitation. I hope it doesn't reflect poorly on the collective wisdom of the Commissioners that I am back here again.

I am going to be speaking about herbs only, not CAM in general, because our specialty is herbal medicine at the American Botanical Council. Basically, I have been teaching, for the last four years now, a course in the pharmacy school at the University of Texas on herbs and phytomedicines in today's pharmacy, and I have had a little bit of experience in dealing with at least those students who are in their fifth year tract for the Pharm.D. degree on how much they know or don't know about botanical medicine and alternative medicine and nutrition in general.

It is surprising and disappointing and, of course, even a one semester course in herbal medicine for these pharmacists, in my opinion, is inadequate to adequately train them for what they are going to have to deal with when they get out there in the open market either as retail pharmacists and/or as health system pharmacists.

I will stray a little bit from the printed remarks that I have given you for the record. Because you have them, there is no reason to be verbatim about it. I would like to share just a few things about our

organization.

We are a non-profit organization that is committed to disseminating accurate, responsible science-based information on herbs and medicinal plants, at the same time honoring the various traditions and indigenous cultures from which those information come.

We were probably the first organization in the country to develop a home-study course for CE for pharmacists on herbal medicines, introduced with the help of the Texas Pharmacy Foundation back in 1994. Also with the Texas Pharmacy Foundation, we started a series of ethnobotany on-site herbal tours to the Amazon Rain Forest, which have now been extended to Belize, Costa Rica, and Africa twice, for pharmacists and physicians for CME credit.

So we actually take pharmacists and other health care professionals on-site into the Amazon and other places where they can see plants that modern pharmaceutical drugs are derived from, as well as how local cultures, indigenous cultures, utilize these plants in a very different but in some cases very sophisticated ways, within the context of their culture, as medicines,

as well as as foods in some cases.

I would like to point out that as far as CME courses are concerned for physicians, right now, for botanical medicine, the only one I know of that is really adequate -- and even then, it is only five days which is inadequate -- is the Columbia University course developed by Dr. Freddie Kronenberg, of which several people here are on the faculty.

I usually lead that off with a course in botanical history. That is the history of herbs in medicine and pharmacy which I think is an important aspect of any CME. People need to understand the relationship that plants and plant drugs have had in the entire evolution of medicine and pharmacy. I think that was alluded to earlier.

This is a five-day course. It was originally designed for physicians. It has also opened up to other health care professionals, and it is taught by, primarily, M.D.s like Dr. Low Dog, who is here, but also Ph.D. pharmacognosists and ethnobotanists. Some herbalists and acupuncturists also participate in the teaching here.

I would like to tell you a little bit about a project we are doing at ABC in the area of CE for health care professionals. We are developing a book of monographs of 30 of the most popular herbs in the U.S. market, focusing on their therapeutics, and this book will also serve as a reference book as well as a CME and CE course accredited now by the Texas Medical Association.

To our knowledge, it is the first time a medical organization has actually accredited CME monographs on herbal medicines; also, simultaneously accredited by the Texas Nursing Association, the University of Texas College of Pharmacy at Austin, and the American Dietetic Association. So these monographs, which are extensively peer-reviewed, focusing on therapeutics, will be marketed for all the four major conventional health care professions.

It will be about 400 pages and will include not only the focus on individual herbs and the information available on them, extensively referenced, but also inclusion of fairly classic herbal combinations from Ayuveda, Chinese Medicine, some from Western Europe that

have been evaluated in published clinical trials.

So we are basically showing that physicians and pharmacists should not just focus on herbals as individual monopreparations, but as well they should be aware of the fact that in many traditional cultures, in fact, the rule is that herbs are used in combinations and the exception is that they are used individually. We will focus on some of those leading combinations that have been the subject of published clinical trials in the West.

Basically, we are also going to be focusing on the branded names of those products used in published clinical studies, at least acknowledging those brands in tabular form in summary forms of tables, as well as various charts, because one of the biggest questions we get in CME and CE courses from physicians and pharmacists are, "We know about ginko, we know about saw palmetto, we saw all the wealth from that analysis of JAMA, but we want to know which brand should we recommend, which brand should we trust. We don't understand these products. We don't understand this industry. We don't necessarily trust it. What brands?"

Well, obviously, those that are subject of published clinical trials are at least the first ones that one should look at for possible evidence of their safety and efficacy, and we will be outlining and highlighting those; not to promote or support those products, per se, but at least to acknowledge the fact that they have been clinically studied, at least in one or more clinical studies. And I believe, in reference to my previous testimony back in October, this also helps provide an incentive for private investment in botanical research because people should get their name mentioned when they do clinical research.

I would also like to point out that Dr. Victor Sierpina, at the University of Texas Medical Branch in Galveston, is a recipient of a CAM Curriculum Development Award from NCAM. I am sure you are all aware of that. I am involved with that program, and there will be, I think, a great deal of herbal medicine material produced in that recommendation for how to develop curriculum in medical schools for CAM.

Ms. Axelrod asked me to deal with a couple of recommendations and questions in my testimony, so I will

try to do this, briefly.

Who should be receiving continuing education? I believe, frankly, all health care professionals should get some form of herbal CE. Of course, it should be tailored to the extent that herbs show up in their particular practice, but particularly physicians of most types, pharmacists, dieticians, clearly, who are constantly helping people evaluate their dietary intake, they should know about dietary supplements and their risks and their benefits. Unfortunately, there always seems to be too much emphasis on the risk and very little acknowledgement or support for the benefits.

Nurses, as well, in various levels, depending on their exposure to patients with respect to the use of dietary supplements.

So, I think that very few medical or health care modalities are basically immune from the proposal that they should get some CE accreditation in alternative medicine, especially botanical medicine. There may be some exclusions, neurosurgeons or possibly orthopedists, but even then more dietary supplements are being shown to be useful in some kinds of classic orthopedic conditions,

neurosurgery as well. So I am not sure that anybody is really immune from the need for being aware of the latest scientific and clinical research on these products.

Who should be teaching these materials? Well, this is a problem. I think there is a paucity of adequately trained people to actually address the issue of how to understand, from a scientific and clinical perspective, the risks and benefits of herbal medicines. I think that there are number of people that are fairly well qualified. Many of them are herbalists and naturopaths who may or may not have an extensive knowledge of conventional biomedicine and, therefore, might be marginalized or might not be well received by some medical practitioners or conventionally-trained practitioners. I hope that is not the case anymore. I think, historically, that may have been the case.

But the fact is that there are a number of people out there who have an extensive knowledge of herbs who are not trained in the conventional medical modality or domain and, yet, that should not preclude them from being able to offer expert instruction in this area.

What should be taught? And how and by whom

should the content be determined? Well, clearly, I have already said history. I think it is important for people to know the history of their own profession, especially as it relates to botanical medicines, and I teach this at the Columbia course. I emphasize it in my pharmacy class, as well. One of our elective texts in the pharmacy class is a book called "Green Medicine," by Barbara Griggs, a British author who chronicles the development of herbal medicine in the West and how it intertwines and has been marginalized and/or oppressed at various times in the Western world over the last 2,000 years.

I also think some degree of information about regulation of herbal medicines needs to be included. I think there is too much misinformation or lack of knowledge by conventional health care practitioners about the regulations and/or underregulation, as the case might be, or lack of enforcement by the agencies, as different people might characterize it, on herbal medicines and the distinction between the regulations on herbal medicines and dietary supplements compared to conventional drugs.

Of course, therapeutics, and it is in here as

well, but I think the therapeutics should focus not only on the risks, but also support the benefits.

The rest of my comments are in here, and I would like to point out that I have also included some recommended reference materials and texts, some basic outline of my class in the pharmacy school, and the basic outline of the monographs that we are publishing at ABC for health care practitioners.

In conclusion, I would like to say that one of the primary recommendations that I would recommend is that any kind of CME or CE courses be adequately and appropriately peer reviewed by people knowledgeable in this area. It is very discouraging to see information published in medical and/or pharmacy texts and journals regarding herbal medicine that are often misleading or grossly inadequate. I have cited a point here in the written portion here.

There is a lack of adequate reviewers in this area, possibly, or the lack of proper review. I think this merits your attention because some of the material being published from conventional publications is lacking in accuracy on these herbal medicines, and this is

something that needs to be addressed if this is going to be included in any kind of course.

I thank you for inviting me.

DR. GORDON: Thank you very much.

Questions. David.

Panel Discussion

DR. BRESLER: This is for Dr. Helms. First, I want to congratulate you on your pioneering work in developing your training program for physicians and how you stood up to the early criticism that you must have had in doing so.

If we look at your program as a model for other training programs that will bring physicians up to speed in CAM procedures, we also have some concerns about scope of practice issues. We have heard a lot of testimony from people who have concerns that patients will go seek alternative practitioners and, therefore, not have access to conventional care which has proven efficacy.

The question that I have is: When you compare the scope of practice for people that have had 200 hours of training versus those who have had 2,000 hours of training, I have no doubt that physicians could treat

musculo-skeletal pain problems with that level of training, but if you are dealing with complex issues like endocrine disorder and so forth, looking at it from a TCM point of view, do you feel that your practitioners have adequate training to be able to handle that as well as the non-medical practitioners? And, two, if you feel that they don't, do they ever refer these complex cases to the non-physician acupuncturists?

DR. HELMS: This is an important question that always comes up in the discussions of comparing the training expectations of physicians who are embracing acupuncture as an additional discipline and those health care providers who have traditional Chinese medicine as their primary or exclusive health management offering.

The physicians who come through the program are all licensed, fully qualified by American and Canadian standards which as we know are the highest qualifications in the world for practicing responsible medicine, and they bring that entire discipline to bear on every decision they make, whether they are using chemotherapy or acupuncture as their chosen treatment modality.

Clearly, 200 hours does not cover the full

spectrum of traditional Chinese medicine and it is not designed to do so. It addresses acupuncture from a neuro-anatomical, neuro-physiological basis, as well as from the tradition of acupuncture, divorced from the rigors of the herbal diagnostic system under the rubric of traditional Chinese medicine.

So the acupuncture quality that a physician trained in medical acupuncture walks out with from a program is, I claim, equal or superior to the acupuncture training that non-medical practitioners are given. The difference has to do with embracing traditional Chinese medicine as a separate discipline. That is where physicians are not engaged.

The complexities, the application of traditional Chinese medicine to complex chronic medical problems, particularly internal medicine problems, are often far more responsive to Chinese herbal input than they are to acupuncture alone. That is made clear to the physicians who are participating in the program. And, when herbal evaluation and treatment is indicated, physicians are instructed to have adequate training himself to address that or to refer the complex patients

to work collaboratively with the licensed TCM practitioners.

So we are not comparing acupuncture and acupuncture with your question. Your question implies the comparison of medical acupuncture which is embraced by physicians for incorporation and integration into their specialties versus the discipline of traditional Chinese medicine as imported from Communist China.

They are different disciplines. They overlap in some of the acupuncture perspectives, but the versatility and flexibility of the acupuncture that is taught to the physicians in a 200-hour program is adequate to responsibly apply it not just to muscular-skeletal problems, but to general medical as well as specialty medical problems as well, as either a sole intervention or as a complement the conventional medical intervention.

When it is serving as a complement to other CAM disciplines, then obviously the physician, as he would with other specialties in medicine, would work collaboratively with other CAM practitioners.

DR. BRESLER: Do your graduates, in fact, do

that? Do they work in collaboration?

DR. HELMS: Yes. Yes.

DR. GORDON: Effie.

DR. CHOW: I think there is value in both aspects, but I wonder if Mr. Lixing Lao would expand on -- because, Dr. Helm, you are saying that the traditional acupuncturists have the same training. Could you elaborate on, without the herbal training, how many hours of training does the acupuncture version have.

The other thing is, are the organizations in communication? Because there is lots of discussion that we should all work together. Perhaps the medical doctors who are trained in acupuncture have not had the exposure to the extensiveness which acupuncture can work with the individual in complex cases and that the exposure is important. Because if you haven't had exposure, you can't expect them to know.

Could you or both of you make comments on that.

DR. LAO: As I mentioned in my speech, I already mentioned that there are two programs. One is acupuncture purely program is about 2,000 hours, and the other program acupuncture practitioner program, usually

about 3,000 hours, approximately.

DR. CHOW: So the acupuncture is 2,000 hours?

DR. LAO: Yes. Yes, approximately. I want to emphasize that usually acupuncture treatment is not just points and meridians. They are also based on the TCM diagnosis. This part takes lots of hours, if I answer the question.

The second question is mainly how to collaboratively work with other physicians. I think this is also, recent years, I think since the awareness of usefulness of acupuncture brings up, more and more physicians get more and more open minded and accept acupuncture treatment. So, from my own experience, I can tell I get lots of referrals from physicians. Also, the medical acupuncturists, we work together very nicely. The acupuncturists also refer patients to physicians when they feel there is a need for the diagnosis for medication from physician, they work together. I think this is the direction.

DR. HELMS: I would like to address your question of the comparison of the training. The 2,000 hours that are involved in training a student wishing to

embrace the health care discipline of traditional Chinese medicine or the acupuncture division of traditional Chinese medicine starts with basic exposure to medical sciences, to the basic sciences, to physical examination and necessary in that process is training a student how to be a responsible and safe primary health care provider.

2,000 hours are not spent exclusively training that person in acupuncture. Physicians come to acupuncture training as added specialties. They are already fully trained as primary care providers, fully licensed as practicing physicians, and they come to acupuncture with the ability to embrace this additional discipline to incorporate into their practices.

So the difference in hours is not the valid comparison. The valid comparison is the content of the program and the evaluations of the skills and knowledge base that are accomplished in each of the programs. I would contend that I would place my best student in equal status with the best student coming from a TCM program and my worst student with the worst student coming from a TCM program, and I think that we have practice parity.

DR. CHOW: The part is that, do you see a collaboration on a larger level? You are saying you are collaborating. Is there a collaboration on a larger level with the NCCAOM?

DR. HELMS: To my knowledge, there is not a direct collaboration between the physician and the non-physician professional societies. There is exchange of the material of the disciplines in that physicians who have gone through full TCM training are teaching in the physician environment and are bringing the quality of the full herbal model and the herbal diagnostics and the application of TCM to complex medical problems either as exposure or as in-depth courses for physician acupuncturists.

DR. GORDON: Tom, and then Charlotte.

MR. CHAPPELL: Mr. Blumenthal, in your presentation we get down to the what should be taught question. This group is hearing a lot of different recommendations about how we handle standards and safety and efficacy issues concerning herbs. We have had recommendations of creating standardization.

As I understand herbs and our knowledge of

herbs to date, we don't know what active elements in certain herbs are doing the actual work. There is more research needed before we could boast standardization. At the moment, we are standardizing markers instead of active ingredients.

Given still the lack of ability to land on a single active ingredient the way we do in FDA sort of orientation to drugs and to build a claim around a single drug, how do you think we should approach the consumer's concern, the physician's concern, for employing more herbs in their well being and health care? What can we do to improve the confusion or the quality?

You do address this in some respects, but the language you use is that it bears clarification.

MR. BLUMENTHAL: Well, thank you, Tom. That is a $64 question you are asking there.

The issue of standardization deals with the fact that herbs are, by nature, chemically complex, which is part of the natural situation, and that different herbs, even the same herb will have different chemical profiles depending on where it is grown, how it is grown, chemotypes, processing procedures, et cetera. This is

anathema to a chemist, pharmacologist, pharmacist who is trying to focus on one single ingredient based on the reductionist biomedical model. At the same time, we have evidence that different kinds of non-standardizable preparations can be clinically effective, as documented in published clinical studies, as published by Dr. Francis Brinker [ph] in "HerbalGram 46."

There are a number of studies on "non-standardized preparations." The issue of standardization goes well beyond chemistry, as well. There are standardization issues that go from agricultural production of these herbs as well, which is from the ground up. I mean, that is another issue as well, but it is part of quality control. The standardization is often a chemical conversation in the popular domain, but it really goes beyond that into quality control issues; determining what seed you are going to use, how you are going to process. Those are all part of standardization.

The issue I think that you were speaking about is how do consumers and health care professionals identify products that are reliable, safe, effective and repeatedly reliable, and that is not always easy to deal

with. There is no published GMPs at this time that deal directly with botanical products. FDA was rumored to have published GMPs, the four dietary supplements that were supposed to be --

DR. CHAPPELL: You mean, Good Manufacturing Practices?

MR. BLUMENTHAL: Yes, Good Manufacturing Practices. Thank you. That deal with quality control, quality assurance, standard operating procedures, et cetera. FDA did release those in the last year. They got slowed down at OMB, Office of Management and Budget. Now, with a new administration, everything is up for review, so we don't know. I think they were withdrawn, I guess, or pulled back. We don't know where the GMPs are at this time, as far as the process, if they will be published in the original form that was recommended by FDA last year, at the end of last year.

We don't have operative GMPs dealing with herbal medicine, so the industry and various members of the industry have had to ascribe to GMPs on their own on a voluntary organizational level. The baseline being the GMPs that are required for all conventional foods because

legally herbs are foods not drugs, except for the few that are approved as over-the-counter drug ingredients like cineole, aloe, cascara, et cetera, and psyllium.

DR. CHAPPELL: But there are GMPs for food, drugs, beverages, everything else that we consume, and herbs are the only ones that have no GMPs.

MR. BLUMENTHAL: Well, herbs do have GMPs, but the GMPs are the default GMPs required for conventional foods. There are no specific GMPs for herbs or dietary supplements. Those are pending, but the GMPs that do govern herbs are the same GMPs that govern tomato juice, apple juice, fruit cocktail, salsa or anything else that is a conventional food, until such time as these new GMPs are released.

Even then, by the way, when those GMPs are released by FDA, at whatever level they are going to come out, based on what tinkering that may or may not happen with the new administration, there is an exclusion for small businesses that exempts various companies. I think the small business exclusion under the federal government definition is something like somebody with less than 300 employees which, as you know, is probably going to exempt

most of the people making herbal products except for a very few.

So the real challenge here, I think the bottom line is that there are a number of voluntary initiatives by different individual manufacturers and organizations to meet or exceed levels of GMP that are not yet required by the government. It is voluntary.

DR. CHAPPELL: But the industry would not resist --

DR. GORDON: Excuse me. I think we really need to focus here on education and training. Afterwards, Mark has already said that he would be available to us for consultation on some of these other very important issues.

DR. HELMS: Mr. Chairman?

DR. GORDON: I would like to go with Charlotte.

Joe, you would like to ask an herbal question?

DR. HELMS: No. I am wondering if I might be given a moment to offer some recommendations from my perspective as an educator in medical acupuncture that ties into some of the discussions that were already brought up this morning, at the conclusion or before the

discussion continues.

DR. GORDON: Sure, if it is brief, because I want to give the Commissioners a chance.

DR. HELMS: I can be brief.

I think it is, first, important to identify that, for physicians learning acupuncture, the environment in which they are learning sophisticated acupuncture is as a continuing medical education event. We have spent a fair amount of time interviewing and working with our clinical preceptors who are involved in academic training programs, and the uniform conclusion is that, in the case of exposure to medical acupuncture to medical students, less is more. A brief exposure showing the clinical value rather than trying to give a full program would make sense. However, when one goes to the resident level or to particularly the fellow level then fuller programs can be done.

In the ideal of worlds, if we are going to open up the spirit of integrating CAM disciplines and CAM consciousness into medical training, I would love to have access to all first-year medical students during the first two weeks of their education so that I could expose

them to the philosophy of diagnosis and treatment models contained in acupuncture so that they could have that in mind as early steps of what they can do to better understand their patients as they are seeing them and, even if it were a fully integrated program, give them gradually more complex therapeutic work as they go through their training.

Obviously, this needs supervision to make it work, which is my second point. The area that needs most attention in terms of growing, simple exposure or more complex training, is trainers. Training trainers, I think is a very important area for considering funding and assistance. It is one of the areas that is underdeveloped in the private sector involved in acupuncture training. It is to be emphasized here that academic centers, university academic centers are not necessarily the best environments for creating responsible exposure to CAM training, even for physicians; hence, the value of the post-graduate CME vehicles.

The other area that could be enhanced for propagation and quality in physicians practicing

acupuncture are resident centers where clinics that are supervised by trained trainers are available to graduates of the CME programs for an extra week or a month or six months of exposure to acupuncture practice. That is not currently available because most of this work is done in private environment. Again, I am not convinced that academic centers are the most flexible to accommodate this notion; hence, breaking some barriers in terms of funding, training the trainers, funding resident programs might need to be considered for most effective integration.

Thank you.

DR. GORDON: Thank you. Charlotte, and then Tieraona.

SISTER KERR: Thank you. This is specifically to acupuncture. Thank you, first, to both of you, your pioneering work. You are part of a long history in America.

I want to follow up on what Effie said. Your presentations, to me, were two of the clearest I have heard on two particular visions on acupuncture education and practice in America. The discussion about how many

hours with the physician and your opinion, we have heard from other presenters in terms of the non-physician acupuncturists.

It was not clear to me, Dr. Lao, when you responded to Effie's question -- I was clear you say you thought the physicians and the non-physician acupuncturists worked together, the medical acupuncturists, and that was working very well. It was not clear to me what your opinion was as to whether or not you thought that was enough hours.

I understood, Dr. Helms, that you felt that, for example, the 2,000 hours, much of what is taught would have been included in your preparations as a primary care level as a physician.

So, I would like you to clarify further what your opinion is on that.

The second, Dr. Helms, is for example, in the 2,000 hours, some people though it would be -- I suspect you might say it is not within your realm to comment on nursing, particularly, for example, nurse-practitioners have a lot of background and preparation. Do you feel, perhaps, something like a 200-hour course could be

appropriate for other health care practitioners and have you done any collaborative work in that area?

The other thing, Dr. Helms, is what would happen if the recommendation came out that the 200 hours for physicians was not felt to be broad enough for the practice of acupuncture in America.

DR. LAO: Let me clarify my opinion. Actually, I addressed it in the speech, but maybe too fast.

SISTER KERR: I got it. Your speech was superb, but I still wasn't clear.

DR. LAO: As I mentioned, actually, I would encourage it. I think it is very good, phenomenal, that lots of physicians get interested in acupuncture training. I think it is a very good thing because they can significantly benefit the patients on a daily basis, because lots of patients come with just with a headache, toothache, and they can use acupuncture to relieve the symptoms.

As I mentioned also in the speech, I will give you an example, like family medicine practitioners, they always refer patient with cardiovascular disorder to the cardiologists. So everybody has specialists.

I think, in my opinion, that professional acupuncture, that is like a specialty. In certain cases, we can refer to each other, with physicians and medical acupuncturists working together. This is my opinion.

I will give an example. At University of Maryland, a complementary medicine program where I work, we work together very nicely, and patients are very happy about the collaboration that we have.

Is that clear enough?

SISTER KERR: So that, if there was collaboration and understanding scope of practice, you feel fine about it?

DR. LAO: Yes.

SISTER KERR: Okay.

DR. LAO: That is right.

DR. HELMS: To address my part of your question, I think it is less important to compare hours of training than it is to compare content of the material covered and the evaluation of the mastery of the knowledge base and the clinical skills through observed evaluation and written examination.

The training that is expected for membership

eligibility. Ultimately, board certification by the American Board of Medical Acupuncture is consistent with World Health Organization guidelines for all acupuncture, all core acupuncture training, not just physician acupuncture training. This is consistent in the teaching programs, as well as in the examination process. So, if we compare content and performance, we are certainly working on an equivalent product in terms of acupuncture ability.

With respect to other medical disciplines that have parallel training in the biomedical sciences, certainly dentists, podiatrists, dental surgeons are accepted into the programs because they fall under the rubric of physician practitioners in the United States and have parallel basic training and clinical training to be able to integrate the material intelligently.

Nurse practitioners and physician assistants because they have additional training beyond regular nursing training probably would qualify for a modified training program, modified from a TCM-based to a 3,000 hour program, if the goal of their practice is to work in collaboration with a physician environment where the

physician is practicing acupuncture.

So, certainly, that would be a reasonable avenue to explore. In fact, a couple of trial admissions were made into the UCLA program of nurse-practitioners and physician assistants. Certainly, those who came through were qualified to handle the material. They didn't have the clinical judgment that is assumed in a physician that goes through it, so additional modification would be necessary to make a program worthwhile, probably an expansion of that.

Your third question of what would my response be if the Commission recommended that 200 hours is not adequate training for physicians in the United States; to that, I would appeal; to that, I would ask you to appeal to the weight of international accord. This issue has been discussed, identified by national societies, international meetings, international societies and international medical organizations such as the World Federation of Acupuncture Societies and the World Health Organization. For the last 14 years, all formal documentation addressing physician training for an appropriate level of safe, responsible and effective

practice has come to the number of 200 hours of formal acupuncture training.

DR. GORDON: Thank you. We have one very quick question, one very quick answer. We are already behind time and we need our full lunch hour, not just to eat in peace but also we have some training that needs to be done.

DR. LOW DOG: Mark, thank you again for coming and for all the great work that the American Botanical Council has done. You spoke about education for health care practitioners which is very important, but I am a little bit interested in your thoughts about education and educational standards for herbalists because that has been raised several times here about variation in training, et cetera. I am not talking about an intact cultural education; if you are a Navajo person training on the reservation, you are going to get the education. I am talking about everything else.

MR. BLUMENTHAL: Well, I wrote an article a few years ago, I got a lot of heat and hate mail on it, called "What is an Herbalist." Because that term is not well-defined under any laws of licensure or practice that

I know of and it is basically used quite liberally by a number of different people, including people who are manufacturing or making products at home, people growing herbs in their garden, people who have a clinical herbalist or medical herbalist type of shingle out that are unlicensedly doing some kind of health care guidance counseling of some sort, some people who have gone to become acupuncturists so they can have some legitimate cache to deliver medicine but within the context of an appropriately licensed modality.

For starting off with, it is unclear what an "herbalist" is in legal terms. In practical terms, I think you and I know that it is somebody who is trying to use herbs for health care purposes. The herbalists themselves, to my knowledge, the ones that get together under the guise of the American Herbalist Guild, I don't think can even agree on this issue is the problem. They spend a lot of their time just discussing should there even be licensure or not. That is one issue. And, to what extent should there be some sort of training.

There is a group called the Botanical Medicine Academy, which is comprised of herbalists and

naturopaths, and they have gotten together with the American Herbalist Guild to try to put together some core curriculum criteria for developing ways to communicate outside the herbal community to health care practitioners. I referenced that in my written remarks. But I think the question you ask is global, and I think it is very difficult to come down with succinct answers to how one sets up criteria for evaluating and training an herbalist because it is such a widespread area and it covers many different modalities and cultural issues as well.

DR. GORDON: We are going to have to stop. I know we could go on for a long time, but we would like to be able, with all three of you, if we have further questions, to be able to ask you about some of these issue. I think you really presented a very good groundwork for us to begin with, so thank you very much.

MS. CHANG: If the last panel would come up to the table before we break for lunch: Denise Murray Edwards, Sue South and Dr. Murray Kopelow.

DR. GORDON: Dr. Kopelow, is the information correct that you have to leave at 12:30? I would like to

ask you to present first, and we will have a few minutes for questions for you specifically. Then, we will ask the other two presenters.

I appreciate your indulgence on this.

DR. KOPELOW: Thank you very much, Dr. Gordon.

For the first person who held up the picture of the new member of the Commission, I have to be home to watch my son run a meet at 4:00 this afternoon. It is incredibly important, and I am grateful for all of you for changing your schedule.

This has been a very exciting morning. I want to thank you, on behalf of the Accreditation Council for Continuing Medical Education, and Tom Kirksey from Texas, the chair, for inviting us to participate. I have submitted some materials and some of our background for you to review and to read.

My goal here in my comments is to explain the Accreditation Counsel for Continuing Medical Education, to answer your questions, and maybe make some comments about some of the interesting things that have already been said. I don't mean to present myself as representing the entire continuing medical education

enterprise. I am the staff person, the chief executive officer of the accrediting body, and my expertise is limited to the operations of the ACCME.

That organization was created in 1981, and actually today is the 20th anniversary of the first meeting of the Accreditation Council for Continuing Medical Education, an organization that is a council of the American Board of Medical Specialties, the American Hospital Association, American Medical Association, the Association of American Medical Colleges, Association of Hospital Medical Education, the Federation of State Medical Boards, the Council of Medical Specialty Societies, representation from the government and Health and Human Services and the public. Those organizations get the credit for our accomplishments. I get the blame for our problems.

The ACCME's purpose is to promote and develop and encourage the development --

DR. GORDON: Excuse me, just one moment. Dr. Kopelow's testimony is under discussion group 1. So if you are looking and wondering, that is where it is, Tab 1.

DR. KOPELOW: It is always nice to be first or maybe not.

So our purpose is to promote and develop and encourage the development of principles, policies and standards for continuing medical education, very much what you have been talking about so far this morning.

Our mission is in the development of these standards for continuing medical education that are utilized by physicians in their maintenance of competence and incorporation of new knowledge to ensure quality medical care for patients and the communities in which those physicians operate.

We fulfill this mission through a voluntary self-regulating system of accreditation, a peer-review process. We have as our prime responsibility to set standards and certify whether or not institutions and organizations meet those standards. Many of you on the Commission are accredited by us or your institutions and organizations are. Many of the previous speakers have been accredited by our organization.

In addition to the setting and certifying with respect to standards, it is important that we relate

continuing medical education to the continuum of medical education, as Dr. Danoff started to talk about this morning, the continuum of medical education. It is important that we evaluate our effectiveness, and that we assist our providers in continuously improving.

You have talked about needs for our providers in the improvement of the continuing medical education enterprise. The whole purpose of this is to assure the physicians and the public and the CME community that CME programs meet the ACCME's criteria for compliance with our rules and regulations, which you have got.

Our system is a national system. We accredit, directly, over 600 organizations. Our state medical providers accredit another 2,000 organizations. Our accreditor-providers put on 50,000 activities a year, 600,000 hours of continuing medical education to 6 million physician and non-physician registrants, and it is an important delivery system for the content, the accountability, and the issues of the content that you referred to today.

An important part of our interface is the eligibility for ACCME accreditation. An organization or

group that puts on continuing medical education for physicians in a medical or medically-related field who can document that it has adopted our policies and a commitment to continuing medical education can be accredited by us.

CME activities are distinguished from activities which are promotional or appear to be intended for the purpose simply of creating familiarity with a specific commercial product.

An organization is not eligible for accreditation by ACCME if, in the judgment of the ACCME, its program is devoted to the advocacy of unscientific modalities of diagnosis or therapy, very much to the point that you spoke about today. You talked about evidence-based. Evidence-based is not a zero or one system. Evidence-based is a grading system where the evidence is graded from anecdotal to the meta-analysis that was referred to earlier, and that is the system that we use.

You asked some specific questions of ACCME: What is the status of CAM in continuing medical education? I don't have the answer in a quantitative

way. We do not keep records of how much of each topic our providers present. If it is something that you need, I can work with you to suggest mechanisms to get that information.

I think it is interesting that we don't have it, that this is not a marginalized or identified group that we know everything about, which is interesting. So we don't have that kind of database, and we do look directly at activities at the time of accreditation.

You also asked: What are the barriers to inclusion of CAM in CME curricula? Well, from all the barriers, we are a regulatory body and we have regulatory requirements. We have eligibility requirements.

So they, theoretically, can be barriers to entry of providers who teach about this content in continuing medical education. There is that potential, and it has to be kept in mind. The incentive is that there is a great need for information exchange about CAM for physicians and all health care practitioners, so there is a great incentive to enter.

Of note, the ACCME went through a strategic planning process in the last year and identified as one

of its imperatives to examine how it deals with the content of continuing medical education. We reward with exemplary compliance and long terms of accreditation if our practitioners can demonstrate the effectiveness of that education in changing physician practice or health status improvements.

It would be interesting, in that task force and deliberative process, if we switched sides and your Commission talked to our process about the value of the content in changing physician practice and health status improvements.

That is the second thing, Dr. Gordon, I invite us to talk about, perhaps, in the future. Those are my comments and thank you for the opportunity.

DR. GORDON: Thank you very much.

Questions from Commissioners. Joe.

Panel Discussion

DR. PIZZORNO: I read, with quite a bit of interest, your written presentation, and ask you to help us deal with a quandary. That is, while CAM continuing education seems to have considerable interest amongst health care professionals and medical doctors in

particular, if you look at the standards here, by defining things as not acceptable, those which are not commonly taught in medical schools, and by defining them also having to meet a standard of evidence -- which, a case could be made that in conventional medical schools right now many things are taught which don't meet that standard of evidence -- it seems like CAM is being arbitrarily excluded from CME.

I speak from personal experience here, having actually approached your organization about getting approved for CME and getting quite discouraged in that process. So there is a problem here. We know medical doctors need education in this area, and yet CME doesn't seem to have standards that allow that to happen.

How do we resolve this problem?

DR. KOPELOW: You have identified the fact that the language that you are reading is 1981 language. The scientific evidence is more popularly dealt with in the context of evidence-based medicine and the grading of evidence. We are working closely with the American Academy of Family Practice who is constructing a system whereby the content of continuing medical education

activities can be looked at in the context of what is the grade of evidence in support of the recommendations for diagnosis or therapy that are being made.

So there is a standard for that that is very important, in addition to the content exchange that was referred to before. I think that that perspective removes some of those perceived barriers-to-entry that are based on the fact that evidence is often taken as meta-analysis of double-blind, randomized control trials.

There are is lot of anecdotal evidence and other scientific and qualitative evidence in supportive of the use thereof which needs to be brought to bear, to be brought out, and to be part of the discussion. That is what our task force is going to look at.

I heard talk of accountability, and it is important. It is just very important, and there is a separation and often a fine line between a firmly held belief and something that has a grade of evidence in the evidence-grading system. It is at that boundary where we engage in this deliberation. You expect the regulatory body to have standards, and we hold them. You also expect them to change, not necessarily at the rate of the

paleontologic record but in some sort of way, but you do expect us to be firm in what we have. Good question.

DR. GORDON: Effie.

DR. CHOW: Thank you. You mentioned in your delivery about assessing the need or interest and that is how continuing medical education is developed. Do you look at the increase in the development and presentation of complementary and alternative medicine in the medical schools? It has been noted that over 65 percent of medical schools now include it in their curriculum one way or another.

Does that not influence your thought about the CME's need, then, to have programs in this area?

DR. KOPELOW: You don't need to convince us or the continuing medical education enterprise. I mean, 75 percent was the highest number I have ever heard, but it is a substantial amount. We have known that for a long time. That is why complementary and alternative practitioners have been part of our group of accredited providers for many years.

They are not prohibited on the basis of the topic, but rather the approach and the firmly held belief

as opposed to the firmly held belief in the context of some evidence, and that kind of medical context is what we see as the level of practice for the educator that we need.

DR. CHOW: I was interested in what you were saying as evidence-based right from --

DR. KOPELOW: Anecdote?

DR. CHOW: Anecdotal, all the way. You do place importance on the anecdotal aspect of it, as much as the meta-analysis?

DR. KOPELOW: Well, didn't you all, when my colleague told her anecdote about her dad and the Vitamin B? I mean, that was an anecdote. That was a story, and you take all of those and thousands of those together and you have anecdotal evidence. One anecdote is --

DR. CHOW: Is one.

DR. KOPELOW: Is one, exactly.

DR. GORDON: I wanted to say a couple of things. One, I would be very interested in taking you up on your offer and talking with you about issues related to CME. So I am happy to come personally as a representative of the Commission. I appreciate that

offer very much.

I also have a question, though. One of the issues that has come up and that we have heard about around the country is that physicians are able to obtain CME, and I have seen this in my own programs as well. Physicians are able to obtain CME for learning about a procedure, a therapy, a technique, a world view, but they are often not able to get CME for learning how to use the practice, whether it is a mind-body practice or herbal practice or traditional Chinese medicine practice.

Sometimes, there is difficulty there. I wonder if you have any thoughts about that and any way that we can bridge that gap between theory and practice.

DR. KOPELOW: Another toughie. You people are definitely paying attention to the material that you are reading.

One thing I can gladly say is, that is mostly an American Medical Association rule, as opposed to an ACCME rule. So I can deflect that somewhat.

The issue is that, what is most important, most important in the medical world that I operate in, is that the medical practitioners know about that which their

clients are participating in and asking about and which their colleagues are prescribing and doing. From a priority perspective, the physicians can't operate in ignorance.

Then, you cross a line as to whose needs the accreditation system for continuing medical education is meeting and what the range and limits that are applied to us. The Federation of State Medical Boards is one of our parent organizations who are responsible for ensuring that physicians are in the continuing medical education that their member boards are using to maintain license, that the content is applicable to what their credentialed and licensed to do. We are accountable to that organization, and we are accountable for our system to meet that need.

The American Medical Association is, again, one of our member organizations, and we are accountable to meet the need of the system in which they work. It also goes to the definition that I talked about, the program needs can't be devoted to the advocacy of unscientific modalities of diagnosis or therapy.

So it isn't fair to generalize all of the

content that we have been talking about today into that restriction because some of it that is considered alternative and complementary has scientific evidence, like some of the acupuncture that we heard about today for which there is no restriction or negative response to.

So it is, as you know, too complicated to generalize.

DR. GORDON: I am wondering, though, if you think it might make sense that where there is an evidence base, generally speaking, to look at broadening it, so that one can include the practice as well as the hearing.

DR. KOPELOW: That is a wise suggestion.

DR. GORDON: Thank you.

DR. KOPELOW: And a safe response.

[Laughter.]

DR. GORDON: Thank you very much. I hope you enjoy the meet. I look forward to seeing you again.

DR. KOPELOW: Thank you very much.

DR. GORDON: Thank you for your forbearance. We are running a little late so that is why we got into this bind.

Denise Edwards.

MS. EDWARDS: I want to thank you for inviting the Oncology Nursing Society to be part of this meeting. We are certainly honored to be part of this group who have done so much and is going to do more for complementary medicine.

The Oncology Nursing Society has had a commitment to education in complementary medicine for at least 20 years, and that is partially I think because it has always been tied to aggressive symptom management, so it has always made sense to provide continuing education in this area. Also, the Oncology Nursing Society has been very responsive to the demand of its members, and they have requested to have sessions on complementary medicine and some skills training at all the annual meetings.

I am also a mental health nurse-practitioner in a complementary medicine center, the Center for Health and Well-Being. That is a center in Des Moines, Iowa. Nice of you to give me the same weather. I wanted alternative weather when I got here.

[Laughter.]

MS. EDWARDS: It has been very consumer driven. It was established by two of the major hospitals in Des Moines and has been very responsive to the consumer needs.

I am going to modify my written remarks, really so I don't overlap and, also, so I avoid that averse of stimulus that you have set up to keep us on track within time limits.

Education in nursing programs, as you have heard, has been very inconsistent. It is somewhat driven by faculty teach what they know well, and one of the things that they may know well is complementary medicine, but they may in fact not know that very well. So you end up with nursing students as well as faculty who are just as vulnerable as the consumer to misinformation.

So one of the recommendations that I would make is to have training programs -- and let me say a little bit more about train-the-trainer. I think the mistake sometimes, from my perspective, has been to set up discipline-specific models, and that is not necessary. We have some wonderful models out there for pain management that invite all members of the health care

team to learn at the same time.

There is a great model in a different field which is ethics which has really helped faculty, and that is the one that is offered at Georgetown, where you bring all the disciplines together to learn the information. The Georgetown model doesn't create an ethicist, it creates somebody who has got a model to bring back for good decision making.

These programs wouldn't train skilled practitioners, they would educate people who could then come back and educate other people in the field. That has certainly been a lack in some of the nursing programs, although you have heard some of them are very exceptional. A good example is the University of Minnesota that offers 11 interdisciplinary CAM interventions, so that nursing students are with medical students are with pharmacy students.

I would also go a step further with that recommendation. For several years, I had the opportunity to teach a wonderful course called "Ethics in Medicine" that was offered through Harvard Divinity School, in extension. So, in addition to the traditional learners

that you would expect to have there, there were many adult learners who came to take the course. There has been a lot of emphasis on bringing back adult learners at reduced rates, senior rates, into the academic community. This way the students not only hear the content, they are interacting with people who are the consumers of the system and can give them a very good idea of what the cultural concerns are in their environment.

To be culturally competent today, you have to know about CAM interventions. That is mainstream culture. That is not even talking about specific entities that come from diverse cultures. We really need to be familiar with that. An example for me recently was when we offered an infertility program and part of it was incorporating yoga, and that was not comfortable for many people for religious reasons in my community. I hadn't anticipated that. I didn't know that that would be a barrier to care. So even, I think, those of us who have been involved in CAM practice for many years may find, as we move around the country, there are particular cultural concerns.

I would also recommend that a core curriculum