is developed at the national level that could really apply across all disciplines, and the model that I use is the AHCPR guidelines. It is a wonderful guideline for management of pain that involves complementary medicines. It would be wonderful to have that so there would be consistency and a more standardized body of knowledge. Now I realize there would be some exclusion in that development, and that is something that has to be addressed later.

For nurse's education for the most part, is going to be foundational, as many people have discussed, at the undergraduate level, with an opportunity to develop more sophisticated skills with more options at the graduate level. Again, I would recommend that a lot of that training become interdisciplinary in nature.

For practicing clinicians, it is essential to include information in professional continuing education. One of the things that needs to be considered in setting these things up are the financial barriers that often exist for nurses to attend programs. The days are over when institutions would send people to programs, would fund their participation in programs, and even would

allow them time off to participate. So these, perhaps, need to be models that can be brought back to institutions, rather than bringing people to the places where they gain that education.

It should not be limited to health care providers. These same faculty could be offering these programs to the larger community and increasing the awareness of people who are going to be using the system. Then, I would invite another group to be part of this discussion besides our consumers, and that is the insurance industry. Because, certainly, there is an area where education needs to take place.

Certainly, as a practicing clinician, that is a tremendous barrier of access to care. If my clients use their own language and talk about wanting to learn some mind-body techniques or relaxation responses, that door is immediately closed. I need to educate them about some of the terminology to even use to access the services. It is appropriate for me to use the DSM terminology. I am not questioning that for a minute. I don't think it is appropriate to expect consumers.

I do think that there is an opportunity and a

welcomeness in some arenas for this education to be part of health care providers, nursing included in that, as well as consumers, as well as the insurance providers. Recently, a care manager for one of the insurance companies was speaking to the Oncology Nursing group, and she said, you know, "Really, having a relationship with me is not to be compared to sleeping with the enemy. I really am a good guy and I really want good care." We need to also make this research available to that particular group.

Knowledge is such right now -- we have just talked about herbs and supplements -- that none of us will have it all at our fingertips. We don't even really have a comprehensive grasp of all FDA-approved medications because the volume of information is expanding so rapidly, so we are going to have to rely on computer technology. So my other recommendation would be that CAM practitioners and educators are very much a part of putting together that technology so, when you plug in your palm pilot to get it updated on drug interactions, included are the best advice and the best wisdom that we have from research on what are the drug interactions with

the herbs that we are talking about because, as we all know, our consumers are certainly using those.

One issue I sort of lost track of in talking about education with nurses, and is a concern to me, is that oftentimes practitioners aren't even documenting what they are doing. So, when we are talking about evidence based and we are talking about care outcomes, then we really need to have some better data to look at.

So, incorporated in any of these educational programs, really needs to be an emphasis on documentation. Why don't they document it? Well, part of the reason they don't document it is their fear of ridicule, of 1,000 different reasons -- they are in my paper -- but it certainly needs to be done.

One other thing I would like to say about models, and that is that we have pretty much, in health care, used a model of we will create the practitioners, we will create the supply, and hope the demand matches it. I think that the consumer has spoken and said that this is what the demand is, so it is inherent in the health care system to start producing the practitioners who are going to meet the demand that we already know is

out there.

Thank you.

DR. GORDON: Thank you very much.

Susan South.

MS. SOUTH: Thank you for the opportunity to be here. My name is Susan South. I am the director of the Associate Fellowship at the Program in Integrative Medicine at the University of Arizona.

What I would like to do is give you an overview and a brief history of our program, and describe for you our educational philosophy in terms of creating an educational model for continuing education for health care professionals, hoping that you will use this information in terms of the model we have created and also the lessons we have learned by going through this process over the past few years to inform your deliberations for your recommendations.

The Program in Integrative Medicine at the University of Arizona began in 1996 with a vision. Dr. Andrew Weil had long believed that reform and a redesign of medical education was necessary to meet both the needs of physicians and health care professionals and the

demands of an increasingly more educated patient population. Dr. Weil and a consortium of his colleagues committed to this vision, assembled to design the framework for a curriculum in integrative medicine, and develop strategies for offering a comprehensive education to health care providers.

This work resulted, initially, in a few continuing medical education offerings for health care professionals, and then in the establishment of an outline for a comprehensive curriculum in integrative medicine.

In this curriculum, philosophical foundation subjects such as philosophy of science, medicine in culture, art of medicine, research education, lifestyle practices, spirituality, mind-body interaction, nutrition and physical activity were included, as well as several therapeutic systems and modalities such as botanicals, manual therapies such as osteopathy and massage, Chinese medicine, homeopathy, and energy medicine.

The program then evolved to offer a two-year residential fellowship in which four physicians were competitively selected each year to relocate to Tucson to

study with Dr. Weil and other integrative and CAM-practitioner faculty. This education focuses on the acquisition of knowledge, the clinical practice of integrative medicine and development of leadership skills.

The residential fellowship, currently in its 5th year, emphasizes active and experiential learning processes in which skills and knowledge are applied to clinical care and management practices, which in turn prepares graduates to assume leadership positions in integrative medicine. This model consists of didactic sessions, discussion groups, a consultative clinic experience with patients, and patient-care conferences which include practitioners from various modalities assembled in one room to discuss and contribute to treatment plans for patients.

In addition to the residential fellowship, a research unit within the program was established. The objective of this unit emphasizes development of relevant evaluation tools, measurement of effectiveness of educational activities and enhancement of clinical decision making of integrative practitioners. The

research staff also provides education for residential fellows, including individual and group mentoring, instructional sessions and facilitation of journal clubs.

Lessons learned from the residential fellowship allowed us to refine the curriculum and develop new instructional models based in adult learning theory and grounded in a philosophy of self care and a strong sense of community. We knew that educating just four physicians per year for clinical and leadership positions in integrative medicine was not meeting the demand of physicians seeking an education in integrative medicine, meeting public demand for practicing integrative physicians, nor forwarding the field of integrative medicine on a large scale. Additionally, we knew that many physicians were not able, for various personal, professional and financial reasons, to relocate to Tucson for a two-year fellowship.

It was then that the concept of a distributed education in integrated medicine evolved, so it has accomplish several goals. First, it would increase the number of physicians being educated. It would allow physicians to immediately integrate their learning into

their medical practice, and it would forward the agenda of the integrated medicine movement on an international scale. But, most importantly, it would allow for thousands of patients to experience healing-oriented medicine through relationship-centered care with their physician.

This new educational concept, named the associate fellowship, is a two-year educational experience delivered primarily over the Web, but also using a variety of other media such as video, audio, printed materials and texts. The associate fellowship requires the physician to spend 8 to 10 hours per week in study, totaling approximately 1,000 hours of instruction over the course of the two-year program.

The structure also requires the associate fellows to attend three separate residential weeks in Tucson. These residential weeks allow the associate fellows to learn and practice skills together, meet and collaborate with faculty and residential fellows in person, and build a sense of community among colleagues who share similar philosophies.

In the associate fellowship, physicians learn

about the philosophy, practice and integration of care through an active and interactive delivery model. Associate fellows read texts, printed materials, peer-reviewed journal articles; engage in interactive exercises on the password-protected Internet site; participate in threaded dialogues with faculty, experts, practitioners and other associate fellows; complete case studies and clinical scenarios modeled after the patient-care concept introduced in the residential fellowship; and conduct field trips, interviews and other practical activities that emphasize integration of the learning into their personal lives as well as into their active practice.

One of the most important objectives for associate fellows is to experience behavior change by integrating the learning with practical application. We consistently present opportunities for associate fellows to challenge their beliefs and behaviors to make resolutions for change.

As a result of this design, the associate fellows are reporting that, after only six months in the program, they are changing the way they practice

medicine. For example, one physician reported that he spends twice as much time now as before in counseling patients on nutritional concepts.

The associate fellowship is a unique educational experience in several ways. The learner-centered approach places emphasis on a balance between delivery of a structured education in integrative medicine with a self-directed, self-explorative process in which the physician is both encouraged and challenged to seek out new knowledge independently and in groups, and address his or her own misconceptions and paradigms about medicine and their role as a healer.

For example, associate fellows recently completed an assignment in which they selected and examined, in groups, a therapy which was considered on the fringe of conventional medicine. They had to find literature about the therapy, examine its uses, discuss indications and contraindications, and share findings with other groups of associate fellows online.

What resulted was a collection of informed dialogues about various fringe therapies that now serve as a resource to which associate fellows can refer, as

well as a sense of pride of ownership that the database was co-created by the entire group. Assignments such as this result in the creation of a bank of knowledge and data virtually impossible to create by any one person, and also in the establishment and maintenance of a sense of community among participants which is the cornerstone of the associate fellowship.

Building a sense of community allows participants to share knowledge, exchange ideas, debate constructively, and gain confidence in a safe and supportive virtual environment. Although distributed learning programs historically have high attrition rates, we believe that our community-based approach will maintain persistence and add to the richness and retention of the education.

So far, we believe it is working. Seven months into this inaugural class, we remain at 100 percent enrollment. However, without hard data to challenge our assumptions and inform our decisions about the future of the program, we could not be nor prove ourselves successful. Therefore, we have created a comprehensive evaluation plan that allows us to examine and analyze

participant and patient characteristics and demographic data, acquisition of knowledge, integration of the learning into clinical practice, program structure, curricula design, and satisfaction with the educational experience from various viewpoints.

We have developed evaluations for each online module, constructed survey instruments that evaluate physician attitudes and practices, and designed patient satisfaction measurements. Since most of the activity in the program is completed online, the data are easily extractable from our database.

This entire instructional design, we believe, is highly effective in delivering this education and requires a diverse team of professionals to administer. The team consists of 10 professionals combining their unique talents in producing the program. It consists of instructional design specialists, content experts, a medical editor, web design technologists and program coordinators.

In addition, the team works with dozens of content providers, reviewers and faculty from all over the world and depend greatly on the contribution of

dedicated volunteers. For example, we have been honored to have been able to work with renowned experts such as Rachel Remen, Marty Rossman, Jon Kabat-Zinn, and Dr. Low Dog.

Each curricular area is coordinated by a development team that works with faculty and content providers to produce the curriculum for delivery on the Web. This concept requires that content experts and faculty provide an education often very different from previous teaching experiences.

Faculty members are expected to be facilitators of learning rather than simply teachers. They assist the development team in the design of interactive exercises and group projects, as well as providing textual content. Faculty also participate online with associate fellows by seeding dialogues with philosophical questions and statements about the curriculum, and creating opportunities for sharing of knowledge and experiences.

Although the associate fellowship is still in its infancy, we believe we are building a solid foundation backed by positive feedback, thus far, from associate fellows, integrative physicians, content

experts and patients, for developing additional educational offerings to other health care providers.

We would be honored to share our success in learning with you and, therefore, invite you to visit us at the University of Arizona to examine and gain a more personal understanding of our educational philosophy and success. With experience in learning from the residential fellowship and evidence and support from the program's research initiatives, we believe the associate Fellowship is an excellent model of a comprehensive education in integrative medicine delivered in an innovative and community-based environment.

DR. GORDON: Thank you. Thank you, both.

Question from Commissioners. Linnea.

Panel Discussion

MS. LARSON: I thank both of you for your very excellent testimony and advice.

I want to direct one question to you, Ms. South, and it has to do with are there -- what is the cost of that associate fellowship, and are there scholarships or monies available to those physicians or health care providers who apply and who serve in

medically-underserved areas?

MS. SOUTH: Currently, we don't have any scholarships available. We are working on developing the criteria for those, and we are targeting physicians both who are of a lower income themselves and also serve underrepresented populations. Currently, the tuition for the two-year program is $25,000.

MS. LARSON: How do the physicians pay for it?

MS. SOUTH: In a variety of ways. Some physicians are self-paying, some are supported by the institutions in which they work, and others are supported by philanthropic donations and other agencies. It is a variety of different ways.

MS. LARSON: What is the average age?

MS. SOUTH: The average of the physicians is 44.

MS. LARSON: So they have been practicing for quite a while?

MS. SOUTH: Yes. What we hear from these physicians, they are physicians who are applying to the program, just overwhelmingly are expressing quite a dissatisfaction with the way in which they are practicing

medicine. These are physicians who I have been told personally on the phone by many of them that, if I don't learn how to practice in a different way, I have to get out of medicine.

DR. GORDON: Yes, Charlotte.

DR. LOW DOG: Denise, I thought your presentation was excellent. I wanted to know if you were willing to develop the core curriculum for the country.

MS. EDWARDS: I would be happy to work on it.

DR. GORDON: Dean.

DR. ORNISH: Just a quick question. I also was very impressed by all the presentations.

Besides the three-week long residential programs, is the rest of it completely online, and is it online in a self-contained way or does it require a live person on the other end for each individual?

MS. SOUTH: It is primarily on the Web. We do have audio, video, CD-Rom. We also have printed materials. They get a packet every month. There are weekly assignments, but every month they are sent one packet that will include all the printed material. So it is a variety of different media that we use, but it is

primarily over the Web.

DR. ORNISH: But my question is, in addition to the material that they get, does it require somebody at the University of Arizona to interact with them, other than during those three weeks of the retreat?

MS. SOUTH: Yes. We do have, as I said, the faculty are required to spend time online with them during the time period that a threaded dialogue is up and running on the Web. So there would be a faculty member, a content expert if you will, that, when comments are made in the dialogues, that faculty member would go in and comment appropriately on their comment or answer their questions.

So, yes, and the team ofprofessionals that we have are constantly monitoring their activity. We have the technology to be able to know exactly when they are online and when they are off and how long they are spending online.

DR. ORNISH: How many people are currently doing that now; do you know?

MS. SOUTH: We currently have 44 physicians enrolled, and they started their program last August. We

just finished our selection process for 55 to begin this August.

DR. ORNISH: Thank you.

DR. JONAS: I take it that a lot of what you are describing actually is part of what is going on in conventional medical education, too, with a lot of interactive online type of activities. Most of that is fairly information-based, similar to what we have heard as a lot of the programs are moving towards, including the accreditation groups.

I am wondering is there any skills-based training as part of this program? Are any of the programs teaching people how to use these in their practices, some of the acupuncture issues, the mind-body issues that we talked about before?

MS. SOUTH: Yes, absolutely. We focus on, like I said, behavior change, and we do design the curriculum so that it evaluates their behavior change in their practices. For example, we recently completed a series of modules in which motivational interviewing techniques were given to the physicians. Not only did they have to read material and answer questions and dialogue online,

but they actually had to conduct some motivational interview techniques. They had to demonstrate that with patients and report back on their findings, as well as the patients reporting back on their experiences with that.

It is very experientially based. It is both an active and interactive education. What we mean by that is interactive, in terms of dialoguing with experts and other associate fellows; and, active, in terms of actually the practical application of the education.

DR. JONAS: So no one is learning acupuncture or manipulative medicine or anything through this program?

MS. SOUTH: Not acupuncture, no. We teach quite a few mind-body techniques. We do cover acupuncture, but Chinese medicine is such a complex system that we realize we cannot cover all of that. So what we do is we give an overview of Chinese medicine that gives them the basis for discussing this type of treatment with their patients and making appropriate referrals to Chinese medicine practitioners.

DR. JONAS: Is there CME credit for this?

MS. SOUTH: Currently, we have CME credit for the residential weeks. We are looking to secure CME credit for the online modules. We are still in the development stage of some of the modules. It is a little bit difficult to get CME credit for online modules, we are finding.

DR. GORDON: Okay. Thank you very much. Thank you, both.

We will adjourn for lunch, and we will return here promptly and begin the next panel at 2:00.

[Lunch recess taken at 1:00 p.m.]

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A F T E R N O O N S E S S I O N

[2:05 p.m.]

DR. GORDON: It is time for us to begin, so if everybody could sit down. This morning we have been talking about undergraduate, and postgraduate, and continuing education. This afternoon the focus is going to be on credentialing and licensure.

So I hope that as Commissioners we will be addressing all of those questions. The people we are having this afternoon are experts in various aspects of this field. So we welcome you and welcome the first panel.

We will begin with Michael Cohen.

Plenary Session III: CAM Credentialing and Licensure

MR. COHEN: Thank you. Distinguished Commissioners, I would like to present five key ideas concerning licensure and complementary and alternative medicine and conclude with some thoughts on the future directions for regulatory authority.

Let's go back in history. During colonial times, the state neither provided nor required health care licensure so anybody could practice treating the

sick, but in the 1760s, physicians began becoming licensed for two reasons: first, to present dangerous or unqualified practitioners from injuring the public, known as fraud control; and second, to ensure greater education, training, and standards for practice, and I call this quality assurance.

Later, states made it a crime to practice medicine without a license. Under these licensing laws, naturopaths, massage therapists, acupuncturists, spiritual healers and others were prosecuted for practicing medicine without a license. In fact, "go to jail for chiropractic" was an early slogan for the profession. Since then, four major groups of providers in CAM have gained licensure in various states: chiropractic, massage therapy, acupuncture and traditional Oriental medicine, and naturopathy.

There are at least three historic models for licensure: mandatory, title and registration. These are three distinct models, although a lot of times legislatures confuse the terms. Mandatory licensure is exclusive. It means that practicing the profession without a license is prohibited.

Title licensure means that anyone can practice, but only persons with the designated title, for example, certified massage therapists, can use that title. Registration means that, to practice, a provider has to register their name, address and training with the state agency, which has the power to receive consumer complaints and revoke registration.

Now there are two additional avenues for regulating professional practice: the first is exemption. For example, often religious healers are exempt from medical licensing laws so long as they are practicing within the tenets of a recognized church and do not recommend medication.

The second is the Minnesota model, which you may have heard something about, which allows non-licensed providers to practice, as long as they meet a number of requirements. For example, they must not render a medical diagnosis or engage in fraudulent advertising or deceptive conduct. So these five approaches represent basic models for licensing and regulating.

Now the Tenth Amendment to the U.S. Constitution reserves to the states the police power, the

authority to determine who will be granted a professional health care license and what the requirements are for that license. State control makes licensure enormously complex.

Each state has a different licensing scheme with different statutory language regulations and then judicial decisions interpreting all of these rules. State legislatures usually rely on national professional groups to establish education and training standards for practitioners and accreditation standards for educational programs and institutions, but members of CAM professions themselves dispute such things as how much training should be required to get a license in any field or the extent to which their training should incorporate conventional medical models or whether such training and standards can truly encourage individualized treatment.

So licensure presents attention between the desire to increase state legitimization and standardization of CAM practices and the desire to keep CAM practice flexible, nonstandardized and linked to intuitive aspects of care. The possibility of decreased individualization and decreased time per patient that

licensure presents, presents a possible dark side to licensure that can temper calls for increased standardization and nationalization, and this can create conflicts about the desirability of licensure, even within CAM professions, and temper interest in more uniform practice guidelines.

Now, once states decide to license a given class of providers, they must address the scope of practice. The map of licensure in CAM is complicated by the fact that some modalities, such as homeopathy or acupuncture, may be included within a scope of practice of several different professions. In other words, quite frequently no single profession has a monopoly on any given modality.

A related complexity is that licensed providers in CAM who exceed their scope of practice can be prosecuted for unlicensed medical practice, and some boundary issues between professions include whether acupuncturists can recommend Western, as well as Chinese herbs, whether chiropractors can recommend nutritional advice, and to what extent massage therapists can offer emotional counseling and support. So the potential for

criminal liability creates fear and uncertainty in CAM practice, as it may be difficult to spot boundary violations.

Now, licensure, as you know, is one of several key legal issues, and they are all related, and some of the related issues include informed consent, malpractice liability and professional discipline. Some of the cases suggest that licensed providers may find that merely integrating CAM into conventional care, in and of itself, could result in malpractice liability, as well as professional discipline.

The regulatory framework governing CAM emerged in the late 19th Century, and regulation in this century requires wisdom and vision. Abraham Maslow proposed that human beings evolve along the hierarchy of personal needs. He called them survival, safety, "belongingness," esteem and self-actualization.

Similarly, from my perspective, legal authority might evolve along a hierarchy of regulatory needs. These include fraud control, quality assurance, health care freedom, integration and human transformation. These needs are not exclusive, but they do potentially

represent different stages of thought about regulating CAM.

For example, fraud control and quality assurance, which you have heard a lot about, are important aspects of licensure, but they are neither the only nor the controlling variables. I will briefly describe the other three as I see them.

The value of health care freedom respects the flow of information such that consumers can make intelligent, voluntary, and autonomous decisions. Integration reflects the value of learning ways in which different medical systems, across cultures and across time, can teach our health care system today.

Finally, transformation reflects the value of protecting the aspect of CAM that deals with personal, as well as social, wholeness. At its broadest and deepest level, transformation involves the maturation of humanity toward notions of individuation, fulfillment, happiness and even enlightenment and planetary evolution.

A unified approach to regulation would account for all five levels. For example, (1) How can states protect consumers against fraud; (2) How can states

encourage standards; (3) What kind of licensure or regulation most clearly enables consumers to make their own informed choices about health; (4) Which approach best respects the integration of different healing models, cultures and traditions; and (5) What kind of licensure or other regulation will best facilitate human transformation.

Such a unified approach has the potential to transcend the sectarian factionalism, turf battles, and professional monopolies that have dominated licensure, and thereby focus on compassion, healing and the best interests of the patient.

So, to summarize, there are five overarching policy considerations that set the framework for licensure in CAM:

First, many providers want licensure to gain legitimacy and avoid criminal liability under medical license laws.

Second, licensure is largely a matter of state law. States rely on the professional organizations to set standards and structures.

Third, licensure has a potential dark side, in

terms of diminishing the heart and soul of CAM practice.

Fourth, several licensed CAM professions may share legal authority to practice a given modality.

Five, there are at least five different models for licensing CAM providers.

A state may choose mandatory licensure, title licensure, registration, exemption, the Minnesota model or some variation or combination of the above. Such a choice may emphasize varying combinations of controlling fraud, quality assurance, health care freedom, integration or facilitating transformation.

I hope that these five overarching principles can serve as touchstones in future debates concerning CAM licensure. By articulating these principles, the White House Commission can help guide the states in their own deliberations.

Lastly, the power to articulate principles is the power to create. Let us create the world that we choose and not the world we have inherited.

Thank you.

DR. GORDON: Thank you, Michael.

Boyd Landry?

MR. LANDRY: Mr. Chairman and members of the Commission, my name is Boyd Landry, and I am the executive director of the Coalition for Natural Health and have been before this body several times. I like to think of myself as the social conscience of the public, providing information to the Commission.

I represent a grassroots organization that represents over 2,500 natural healers nationwide, and I appreciate the opportunity to address this distinguished panel today, for longer than three minutes, concerning a matter of utmost importance to my organization's constituency and to the public at large.

The purpose of today's session is to discuss whether, how, and by whom national standards and/or certification procedures are established for CAM practitioners. I can save all of us some time by first addressing the fundamental issue of whether national standards are needed. The answer to that question is a resounding no, thus eliminating the issues of how and by whom.

The need for federal regulation in this area may be summarily disposed of for two reasons: (1) There

is no evidence that traditional natural health therapies pose any material risk to the consuming public, so the primary prerequisite for regulation is absent; (2) Industries that are heavily regulated by the government easily account for half of American fatalities, both directly and indirectly, each year.

So, why assert the supposition that government regulation would enhance consumer safety? If the issue is not about consumer safety, then what is it really about?

Furthermore, as Jeffrey Goin, my organization's president, pointed out in his testimony to this Commission in the New York Town Hall meeting, the issues of whether a health-related profession should be regulated, and if so, how, within the sole province of the states. The local circumstances and needs that exist in one state are very different from those prevailing in other states. Only the lawmakers, consumers and practitioners in each state can know what, if any, level of regulation is appropriate for that state.

The Tenth Amendment to the Constitution clearly states the powers not delegated to the United States by

the Constitution, nor prohibited by it to the states, are reserved to the states respectively or to the people. Therefore, we feel it inappropriate for a federal agency, department or advisory board to insert itself for purposes of mandating or even recommending processes or guidelines for regulation at the state level.

If this Commission were to engage in this activity, it would be entirely unprecedented. The federal government does not set professional requirements and standards for doctors or lawyers, and it should not attempt to do so for natural health practitioners.

Additionally, the Executive Order that established the White House Commission on Complementary and Alternative Medicine Policy contained no specific language that directed this Commission to concern itself with matters of regulation or licensing CAM modalities. Again, the establishment and maintenance of professional standards and qualifications for natural healers, as with all local professionals, must be left to the states.

Now back to the point that I made earlier about the real motivation for enacting licensure laws. Nobel Prize-winning economist Milton Friedman once stated, "The

justification for licensure is always the same, to protect the consumer. However -- observe who lobbies for imposition or strengthening of licensure. The lobbyists represent the occupation in question, not customers -- I am, myself, persuaded that licensure has reduced the quantity and quality of medical practice. It has forced the public to pay more for less satisfactory medical service."

Echoing this point, Walter Gelhorn, renowned administrative law scholar and two-time winner of Harvard's triennial Henderson Prize, the country's highest award for administrative law scholarship, once observed, "Only the credulous can conclude that licensure is, in the main, intended to protect the public rather than those who have been licensed," or, perhaps in some instances, those who do the licensing.

Attorney and author, Michael Cohen, who sits to my right, in his first book stated, "Licensure, creating specialization and professional monopoly, has always allowed licensees to fend off non-licensed competitors." He further notes that medical licensure has proven ineffective in controlling incompetent or fraudulent

practitioners.

Mr. Cohen also astutely observed, "Since medical licensing boards are staffed by individuals drawn from and committed to promoting the licensing profession, medical licensing accentuates the protections of the interests of parties other than patients."

As this Commission well knows, more and more consumers are "voting with their feet" where access to natural health modalities is concerned. A frequently cited 1997 survey in the "Journal of the American Medical Association" reported that 42 percent of Americans used at least one of 16 alternative therapies during the previous year.

Another intensive study on alternative medicine, published in the November '98 issue, stated that conservative estimates placed consumer spending on alternative therapies at $21.2 billion in 1997. This figure is up $14.6 billion in 1990. The study further revealed that the majority of people who sought alternative therapy services paid all costs out of pocket. Most consumers apparently recognize that the prevention of disease and the maintenance of good health

is always a more cost-effective approach to health care than the necessity to cure disease.

HCFA estimates that national health expenditures will double by 2007 to exceed $2.13 trillion. As the dollar figures associated with biomedical delivery continue to skyrocket, it is no wonder that what has been termed the field of Complementary and Alternative Medicine is rapidly attracting the attention of both biomedical practitioners and pharmaceutical companies alike. Cost-effective and prevention-oriented therapies present these industries with an opportunity to substantially offset their current costs of operation, while simultaneously improving consumer satisfaction. It is imminently reasonable to conclude that money, rather than safety or efficacy, is the driving force behind the new-found attention and the efforts to justify the regulation of natural health care.

It is also interesting to note that until quite recently most natural health modalities were, by and large, ridiculed or shunned by parties to the allopathic medical model -- to the degree that many patients were unwilling to admit to their own doctors that they were

also clients of a natural health practitioner. However, the recent documentation of consumer interest and the tremendous dollar amount that it represents has transformed "charlatans and quacks" into prime targets for takeover or forced assimilation.

Another reason that exclusionary regulation of traditional natural health therapies is not advisable is because of the enormity, variety and history of the universe of natural healers. This universe includes, without limitation, generational healers; Central and South American curanderos and curanderas; French treaters; English herbalists; Native American tribal healers; other traditional naturopaths, and a wide variety of energy and other natural healers in this country who use methods and remedies proven effective over thousands of years and which have been handed down from generation to generation. We are, in many instances, speaking of therapies that have been consistently and successfully used for millennia. In other words, "if it ain't broke, don't fix it."

The objective of the White House Commission should be to enable and expedite the flourishing of

natural health in this country, not to restrict it. Growth and availability of these vital services will not come about by giving consumers fewer choices through restrictive licensing and other regulatory procedures that have already proven to be a dismal failure. This is evidenced by legislatures in over 18 states that have soundly rejected this type of restrictive licensing legislation over the last four years.

In this regard, if the Commission is to look to any developments at the state level, rather than pursuing a restrictive and exclusionary course of action such as licensure, it would be more prudent to evaluate the feasibility of implementing innovative and progressive legislation like the Complementary and Alternative Health Freedom of Access Act, Statute 146A, which was signed into law in Minnesota on May 11, 2000. This act listed 22 examples of complementary and health care, such as naturopathy, homeopathy and herbalism, et cetera, that were exempted from the practice of medicine, thus enabling a variety of natural health practitioners to operate without fear of prosecution. The law mandates that all practitioners be required to present each client

with a Client Bill of Rights before services are provided. The document must include 17 items of information prior to initiating the consultation.

In conclusion, I would like to reiterate the point that many natural health modalities have histories that predate conventional medicine and our government by thousands of years, and neither our government nor the biomedical community have any business involving themselves in the administration of something that they neither fully understand nor can improve upon, and thus, should certainly not be allowed to happen under the false pretense of protecting consumers.

There is absolutely no evidence that these natural therapies pose any material risks to the consuming public, and the proof of their efficacy is found in the duration of their practice. If the services that these healers were ineffective, they would not be flourishing as they are now.

Simply stated, the most important litmus test for these service providers should be the one administered by consumers and the competition of the free market rather than unnecessary attempts at restrictive

and exclusionary regulation.

Thank you for your time and attention, and I hope I did it under 10 minutes.

DR. GORDON: Thank you. You did fine.

Sharon Hall?

MS. HALL: Good afternoon. Thank you for the opportunity to testify before the Commission. My name is Sharon Hall. I am vice president of Risk Management for Washington Casualty Company. Washington Casualty Company is a licensed medical malpractice insurance carrier in the Pacific Northwest. The company started providing liability insurance coverage for complementary and alternative medicine practitioners in 1995.

The following testimony is based upon our experience in providing insurance and risk management services for primarily naturopathic physicians and acupuncturists in the Northwest, and that is primarily in two states, Washington and Oregon.

To give you a little bit of background, when our underwriters look at insuring a CAM practitioner, we require an application form be completed not unsimilar to what we require for a traditional physician. The

application and a number of supporting documents are then looked at and evaluated. These include a current licensure or certification, a current CV or resume, patient informed consent form that is utilized for treatment.

For acupuncturists, we look at consultation, emergency transfer and referral form that is required by the State of Washington; any advertisements, promotional materials or marketing materials utilized by the practitioner, as well as the letterhead and billing statement. Again, that is to look at and assess for possible group exposure practices.

We also look if they have had previous malpractice insurance by including a declaration sheet. What we found is that we are usually the first insurance company that those practitioners have ever had. Special attention is also given to medical education, continuing education program or courses taken, the nature of the practice, claims history, and any past disciplinary investigations or proceedings. For naturopathic physicians, we also look at and inquire as to if they are doing any kind of obstetrical work or if they practice

acupuncture.

Legislation in Washington State actually requiring health insurance to cover services by all licensed or certified health care practitioners in the state, including CAM practitioners and licensure laws, has led to the formalization of certain CAM practices. Examples of these are referral arrangements and informed consent documentation.

Requirements imposed as a condition of reimbursement for services has also necessitated CAM practitioners to develop more guidelines to address standard operating procedures. These procedures are fairly similar to what we see in our traditional physician office practices.

Conventional medical practice has also initiated the development of clinical practice and case management guidelines for various types of diagnostic treatment. These are being utilized as a standard of care in many clinical settings, and while certain procedural guidelines can successfully be developed and utilized to promote standards of care in complementary and alternative medicine, additional research is needed

to evaluate the safe and effective use of various modalities of treatment.

If national practice standards of care are developed, CAM practitioners will need to utilize the guidelines in their practice or document, in individual circumstances, any deviation for guidelines not being followed. In either case, guidelines, with compliance or lack thereof, may be used in a malpractice case by either party to advance their position.

Our experience in the claims of CAM practitioners for negligent care are that they have less frequent and generally less severity of harm than claims against conventional health care providers. Our loss experience for homeopathic and naturopathic physicians are generally double that of acupuncturists. When a similar comparison is made between naturopathic physicians and insured family practitioner and internal medicine physicians, the CAM physician loss experience tends to be five times lower. This analysis I base on an analysis of open and closed claims to Washington Casualty Company from 1995 through the Year 2000.

A couple of things I would like to mention with

those statistics: First of all, we do have a small sample size. On average, we insure about 179 naturopathic physicians each year, and for acupuncturists during this time it is about 155 practitioners. Also, claims may not have been resolved or additional payments and expenses may be incurred because some of these claims are still open. Also, some claims may not have yet been identified or reported, particularly for the past couple of years.

Differences in loss experience between insured CAM practitioners and conventional physicians has not been formally studied in our organization, but I feel that a number of factors could be associated with this difference.

Among these, may be more active involvement in the patient's own treatment regime, more time actually spent with practitioners or with patients, a comprehensive medical and social history-taking, and a practice that generally involves less-invasive procedures with less risk of complication than traditional medicine practitioners.

Based on this and our experiences, I offer the following recommendations for your consideration:

I concur with this morning's session with the need to educate conventional medical practitioners about CAM, not only to promote collaboration in patient care, but also to avoid possible adverse effects related to the interaction of various treatment modalities. This would also include medical education, as well as education of those physicians that are now out in the community practicing;

Consider state licensure or certification of CAM practitioners to regulate and provide a common standard of practice. This would assure a minimum level of competency. With discretion of implementation of the scope of practice, that often leaves questions as to what is within the legal realms of each practitioner;

I would encourage you to support evidence-based research to promote the efficacy and safety relative to CAM therapies. This would also help promote standards of practice;

And then, lastly, to promote confidential, nondiscoverable CAM quality improvement and peer review activities to enhance the quality of care. By looking at patient outcomes and processes that may be involved in

unexpected or in undesirable treatment results, you can improve the quality of care.

Thank you.

Panel Discussion

DR. GORDON: Thank you very much.

Questions from Commissioners?

Dean?

DR. ORNISH: This is a question for Boyd Landry. I guess there are a couple of questions, and I will try to make them both brief because I know I am only supposed to ask one, so I will pretend it is one long question.

[Laughter.]

DR. GORDON: With two parts.

DR. ORNISH: If you don't think that anybody should be licensed anyway, why is the state better than the federal government?

It seems like you are arguing against any licensure. So why argue that the state does a better job of it?

MR. LANDRY: No, I didn't argue that the state did a better job, I argued that it is the state's

purview.

DR. ORNISH: Because?

MR. LANDRY: Because the Constitution calls for it to be their purview.

DR. ORNISH: I see.

MR. LANDRY: So that means the argument of whether something should be licensed or not is devoted to the state level, and that argument takes place there. It should not take place here.

DR. ORNISH: You also make a pretty strong statement that natural approaches are always harmless, but we have heard a lot of testimony from any number of people that while, in general, natural approaches tend to be safer, they are certainly not harmless in all cases. The interaction between anhipramine and St. John's wort is only one of many examples.

Certainly, if that were true, there would never be any need for Sharon Hall's malpractice insurance for alternative practitioners. It seems to me, you weaken your argument by making statements that are so blatantly false.

MR. LANDRY: You have a greater chance of being

struck by lightning than having a harmful side effect from a natural therapy.

DR. ORNISH: Well, Darien Brinkley is here. He might take issue with that, but that is another story.

Based on what?

MR. LANDRY: Just the evidence that I have seen out there, in terms of the statistics that have been gathered on harmful side effects in natural therapies.

There are these examples that occur. For example, you mentioned St. John's wort and a particular drug. That may or may not occur, but I think, in each individual person, the potential for that side effect is different.

DR. ORNISH: Are you saying that natural remedies have never had any negative side effects ever?

MR. LANDRY: No, I didn't say that.

DR. ORNISH: Then I am misunderstanding what you are saying.

MR. LANDRY: What makes these therapies distinct is the fact that they address the person as a whole and are dealt with that way, and are not breaking us down into individual parts and trying to fix a

particular part.

So what I am trying to say is that the usage of these therapies may have some minor cases of harm. I have yet to see an exhaustive amount of data on it, but for the most part, there really isn't a whole lot. There is far more in other areas of regulated industries than there is in this.

DR. ORNISH: Okay.

MR. LANDRY: We could debate all day, I am sure.

DR. GORDON: Wayne, and then George, and then Tom, and Tieraona. I'm sorry, Tieraona first. How could I forget?

DR. LOW DOG: I want to thank all of you for your presentations. I would like to actually talk to both Mr. Cohen and Mr. Landry.

I would certainly agree with you that, as far as comparison of pharmaceutical drugs and other things, that when you compare most natural remedies that are used appropriately, that there is far less risk of side effect or adverse reaction because they are far more dilute compounds, which is why, often, they take longer to work

and they are usually less associated with so much toxic side effects.

I think we would all agree, though, that plants are pharmacologically active substances, and they can be used inappropriately, and that given the right circumstance, people can use them harmfully.

We had a patient recently, it was a couple of years ago at the VA Hospital, who was admitted in what looked like florid Digoxin cardio-toxicity, who had been given, from a local healer, a remedy for his failing kidneys, which had actually worked quite well for his failing kidneys, but he didn't have failing kidneys. He had congestive heart failure.

The plant that he had been given is very effective for congestive heart failure. It is inmortau [ph], which actually contains the cardenolide cardiac glycoside. However, he was toxic from it. It wasn't an interaction, it wasn't used with anything else. There are better ways to deal with congestive heart failure. Sometimes the problem with unlicensed therapists is that we don't know what we can't treat. We don't know where we step out of our boundaries or our scope of practice.

Now, do you feel, either one of you, when you are talking about licensure and scope of practice, other than an informed consent, should there be any scope of practice for herbalists, just an herbalist? Should there be any type of scope of practice there? Should there be any sort of licensure, education requirement, anything, so that we don't harm the public?

MR. COHEN: If I could just add a couple of correctives. First of all, thank you for quoting me, but it was not my conclusion that licensing boards are ineffective. I simply cited other scholars who have done original research, who have done that conclusion as a kind of warning that licensing boards don't always do what we hope and expect that they will.

Secondly, I am personally neither in favor of nor opposed to licensure. I simply tried to point out that there is a possible dark side that has to be taken into account as a kind of corrective.

Thirdly, the purpose of licensure is not simply to control fraud and create standards, but there are other potential values that come into the mix. Specifically, in terms of scope of practice there is a

legal rule called the Duty to Refer, which basically says that when providers, such as chiropractors, exceed their scope of competence, they must refer to a medical doctor.

I would say that the Duty to Refer is a good generalizable principle for other professions, but at the point of the scope of competence, not the scope of practice, which is set by the standard, but the scope of what they are skilled and trained to do. At the point that that is exceeded, one should then refer the patient to somebody else, and that provides a kind of safety valve of protection.

It is a little bit complicated with herbs because, as I mentioned, one modality can be the province of several disciplines. So that is a big political battle, largely at the state level: who should have the authority to recommend herbs; what kind of evidence is required; should there be comparable training for M.D.s and non-M.D.s in this area. These are all open questions.

DR. LOW DOG: But you have made an assumption, though, about scope of practice and the ability to refer, the duty to refer. A chiropractor has training and is

licensed.

I am not talking, really, about culturally intact healers. I am really talking about a lot of people who have read a few books and are healers. They are probably very well-intentioned and big-hearted, good people, but they may not have the training to actually know when they should refer. You have to have some basis to know when you are supposed to refer.

Giving an herb for your kidneys not working --

DR. GORDON: Tieraona, excuse me. Are you asking a question?

[Laughter.]

DR. LOW DOG: That was my question. Again, my question just comes back to, how would you know to refer?

DR. GORDON: So, Michael, do you want to be any more specific about any thoughts about licensure in this area?

MR. COHEN: Sure. Let me just clarify that if I could.

The duty to refer applies to licensed professionals. If somebody is unlicensed, and they are doing something that could fall into a licensed category,

for example, diagnosing and treating disease, they could be prosecuted for the unlicensed practice of medicine, and possibly other professions as well.

So the unlicensed herbalist who recommends an herb and doesn't know what they are doing could be prosecuted for unlicensed medical practice. I hope that helps.

DR. GORDON: Okay. Thank you.

Wayne, George, and Tom.

DR. JONAS: Even if they do know what they are doing, they could be prosecuted.

It seems like we have an experiment going on, a natural experiment going on right now, at least with the Minnesota model, that might be worth evaluating. Although, I dare say it would be clear that you would see less adverse effects from natural treatments precisely because the insurance malpractice data that you described, which has, in my opinion, to do with the severity of the illness and of the treatments that are provided, not because one system is any worse or better than another.

Anesthesiologists have very, very high

malpractice, and it is because of the risk of the type of practice that they are involved in. This, to me, is data that is not very useful. It is more polemic than anything.

My question really is, is there a role for the federal government in licensure, since it is under the state purview? What is our job here? Do we have any role on this, as a federally commissioned agency, to be involved in this at all? And if so, what would that be?

DR. GORDON: Michael, do you have any thoughts? Or Sharon? Boyd, we have heard yours.

[Laughter.]

MR. COHEN: I wrestled long and hard with whether I could come up with any recommendations, and I think I made the choice not to, not to pass the buck or get off the hook, but simply because so much of it is dependent on state law, and so much of it occurs on a local level and is experimentation involving public bodies, a lot of debate, and a lot of it really is judge-made law, things like scope of practice, the duty to refer.

And so, in part, I think the debate is out of

the hands of the Commission. But I think, that having been said, one can set overarching principles to try to shape the debate: What are the values that CAM represents; what are the values that this body has said is its overarching themes; are there other things to look at once we get beyond the debate about standards; and is licensure a good thing or a bad thing; and, what are the pros and cons.

So I think that by creating a very rich template for the debate, the Commission can then guide the states that are going to go on and repeat the debate in their own terms.

DR. GORDON: Sharon Hall, any thoughts?

MS. HALL: I agree pretty much with what Michael has said. From the medical malpractice perspective, we utilize standards of practice or scope of practice to identify or to defend a claim.

First of all, we do not insure anybody who is unlicensed or not certified, and I don't feel that my company would go into a state that did not have licensed or certified, say, naturopathic physicians or acupuncturists, and insure them.

So, from that perspective, we are focusing on a certain type of CAM practitioner that we feel very comfortable with that gives a certain standard of care. By their very nature, I think we have isolated some of those type of practitioners to provide the type of care that, from an insurance perspective, we would like to see given to the public.

DR. GORDON: Thank you.

George?

MR. LANDRY: I would like to respond to the question, Dr. Gordon.

DR. GORDON: Sure.

MR. LANDRY: I think one thing that should be abundantly clear, in the history of this country, we are constantly debating and battling over to what extent government gets involved in the lives of the people. Where something may have been appropriate 50 years ago, may not be appropriate today, and I think that is something we always have to pay attention to because some of the things that may have been appropriate 50 years ago may be exactly what has caused the problems today.

That is always something that has to resonate

in the back of our minds as we grapple with the role of government in the lives of the people.

DR. GORDON: Thank you.

George, and Tom, and then Joe.

MR. DeVRIES: Question for Michael Cohen.

I know in the organization I work with -- I work with health plans to help them provide benefits for employers -- and I think, consistent with what Sharon Hall has said, the understanding of what we see is if the provider isn't licensed, then there is really no ability to work with them from a position of third-party reimbursement.

From the position of the Commission, as they look at what kind of influence they can have across the country as related to CAM, while the states regulate health care, potentially the White House Commission could recommend minimum statutes related to licensing of provider groups like acupuncture and naturopathy.

What would be your thoughts related to that? It ultimately would come down to the states' decisions, and they would have to enact licensure or statute, but would we be appropriate to make a recommendation?

MR. COHEN: I am trying to understand your question. Are you asking whether you should recommend that specific providers be licensed in all states?

MR. DeVRIES: There is a tremendous inconsistency, for example, with acupuncture, on how it is licensed across the country. Naturopathy is only licensed in roughly 11 or 12 states, and there are active efforts to have it licensed in other states. Yet, for many states, they don't have a guidepost on which way to go with these statutes, and they are looking to what has been done before, but there is not a strong guideline for them in terms of what they could emulate and enact in their states.

MR. COHEN: I think a couple of things could be done. One is the House of Lords recommended, basically, that the professions consolidate their regulatory bodies so that they make more sense.

You could recommend that if there is a non-licensed profession, for example, energy healing, that groups in that therapy, aroma therapy, that they come together and create more coherent professional structures because those professional structures can be

prerequisites to licensing, as they have been in the other professions. So if that is a desirable goal, that is one recommendation.

On the other hand, I think we have already talked about some of the problems, in terms of having uniform standards, the second part of it. There would be more consistency. Inconsistency is a problem. For example, for physicians who want to refer across the states, they don't know what an acupuncturist means in Tennessee versus in Alaska.

On the other hand, the problems of greater consistency should also be acknowledged, the uniformity, the standardization. So that, some of the problems of medicine might be repeated in CAM, which I refer to as losing the heart and soul of practice, again, recognizing that tension.

So I would not necessarily be in favor of mandating consistency, but perhaps encouraging a study of what could be done to harmonize some of these issues.

Finally, I think it would be difficult to come up with a recommendation as to which providers should be licensed uniformly across the states. Acupuncture, there

are 37 to 40 states that license non-M.D. acupuncturists, but when you look at the broad spectrum of CAM, which professions are you going to recommend that they obtain licensure, and on what basis, and what are the criteria that you would select that would give a profession candidacy for licensure?

In my own experience, working with Dr. David Eisenberg on the Massachusetts Commission, is that these issues are very, very thorny at the state level, and they are very complex and really require a lot of input. So it would be nice to have national policy on these issues, but I think that it is very complex and, in practice, may be a hard thing to achieve.

I hope I have started to answer your questions.

DR. GORDON: Thank you.

Tom?

MR. CHAPPELL: Michael Cohen, I would like to ask, since you have made clear that you don't have a recommendation for licensure or non-licensure, could you tell us how you would go about, as a consumer, discerning a CAM practitioner for you or a member of your family?

MR. COHEN: If I understand the question, it is

whether licensure is important, or how important a variable is the fact that somebody is licensed and making a choice.

MR. CHAPPELL: That is another way of looking at it. I am really just asking, how would you make a selection, as a consumer, and is licensure important?

MR. COHEN: If I take off my "scholarly hat," I personally go to providers through a variety of routes, some of them are recommended by a physician, some are licensed, some are not. Some people have the highest certification and use science- and evidence-based medicine. Others use intuition.

When I go into a health food store, how do I pick echinacea versus some other supplement? Do I read what the JAMA says? Do I consult with a physician? Do I listen to my grandmother? Do I throw the bones and consult the spirits? Do I trust my own intuition? Do I talk to friends? I think that all of these things are important to me.

So, from a public policy perspective, the question is which sources of information, if I could just reframe it a little bit.

MR. CHAPPELL: Yes.

MR. COHEN: Are there sources of information, in addition to or beyond the mere fact that somebody is licensed, that one should allow into the mix, into the system, to influence consumers; is there a different way of thinking about it.

That is why, provocatively, I put in this goal of transformation, because, it seems to me, that transformation is the heart and soul and essence of a lot of therapies that we don't understand, that we don't know how to look at, that may require skills training or an experiential base to incorporate.

Thereby, if that is an important goal, it just opens up the way that we look at this a little bit.

MR. CHAPPELL: So discovery might be dampened by a licensing requirement. I think you have said that, actually, in your paper. That is helpful. Thank you.

MR. COHEN: I am just saying I think we should keep an open mind, and I think, as Wayne Jonas said, we are in a period of experimentation, where things that came in in the 1700s might look different in 50 years.

DR. GORDON: Thank you.

Joe?

DR. PIZZORNO: My question is for Boyd Landry.

Is there any mechanism for public accountability that you would recommend or support for lay healers with little or no training, to help provide some safety for the public?

MR. LANDRY: I think the Minnesota law is probably the best thing that I have seen in 10 years. Diane is here, Jerry Johnson is here. Both were, integrally, a part of that process of getting that law passed. It provides informed consent, with government oversight without all of the things that strangle providers. That is about as easy a way of answering it.

DR. GORDON: Thank you.

We are going to have a chance, in the small groups, of course, to revisit all of these issues, and then plenty of time to discuss them among ourselves.

I thank you three experts for coming and helping us with this.

MS. CHANG: If our last three speakers would come up and join us: Steve Olson, Clem Bezold, and James Winn. Thank you.

DR. GORDON: Thank you. We are going to begin with Steven Olson.

MR. OLSON: Good afternoon. I am president of the American Massage Therapy Association, or AMTA. I think by the time I finish my 10 minutes, I might calm down.

Before entering into my comments, centered on the topic specified for this hearing, I would like to make a few general comments regarding the collective history of massage, a snapshot of where we are today, and a bit about AMTA.

The practice of manual therapies extends into the distant past and can be said to have existed since humans first organized themselves into groups. They have been present in all cultures, in all periods of history. As is the case with some other therapies, they predate the practice of allopathic medicine.

In Western traditions, the massage approach was systematized in the mid-1700s. While we think that the current effort to consider whether massage therapy should be included in the practice of medicine is unique to this time, we have been here previously.

In the 1930s and '40s, practitioners of soft tissue manipulation faced the very same issue. Many masseuses and masseurs moved into the world of physical therapy. Of those who decided to continue outside of the allopathic medical model, a group gathered in 1943 and formed AMTA. As a profession, we owe a great deal to these individuals. In effect, they kept alive the body of knowledge that has emerged as the verifiably distinct profession and practice of massage therapy.

The snapshot we are presented with today is very interesting. Massage therapy has been identified by numerous sources as the second-most utilized approach in the world of CAM. According to consumer surveys commissioned by AMTA, the use of massage therapy among adult Americans has doubled since 1997. Our surveys also tell us that massage therapy is overwhelmingly perceived by the public as having therapeutic and/or medical benefits. Forty-four percent of adult Americans think massage therapy should be among the core benefits of their health plans. The consumers' voice is clear. They value what we do.

From the practitioners' side, AMTA members tell

us approximately 15 percent of their practices are medical in nature, while the majority identify more closely with the description of working within the wellness and relaxation models. In the last five years, AMTA has almost doubled its membership to 44,000 members. We are the primary voice in the profession, and our profession is a major player in the world of CAM.

The topics of education and training have been addressed in our preliminary documentation. To summarize them: The training of massage therapists is carried out by proprietary and undergraduate institutions. AMTA established the AMTA Council of Schools in 1982 for the purpose of establishing educational standards for massage therapy. There are currently 235 Council of Schools members from a field of about 700 schools of various levels throughout the country.

In 1989, in conjunction with the Council of Schools, AMTA created the Commission to approve and accredit massage schools. In November of 2000, the Commission on Massage Therapy Accreditation, COMTA, submitted its petition for recognition as an accrediting agency to the U.S. Department of Education. COMTA

currently accredits 53 massage programs which have demonstrated a required level of competence. At the request of schools and other associations, COMTA will be developing standards to accredit programs teaching Asian bodywork.

When COMTA receives its approval as an accrediting body, the profession of massage therapy will join the professions of acupuncture, chiropractic and naturopathy in having an accrediting body internal to the profession that addresses both institutional and programmatic accreditation. AMTA has made the promise to COMTA to provide financial support in perpetuity.

There are several other accrediting bodies that are serving massage therapy schools. However, none of them are currently able to thoroughly examine the programmatic side of massage programs. It is critical to the profession to have a valid accrediting body that can focus on the subject matter being taught to future massage therapists.

One of the major challenges in the training of massage therapists is to teach the manual skills needed to be successful. The profession must rely on training

programs to provide these skills to students, as they are virtually impossible to measure, with any validity, when it comes to testing for licensure.

The length of educational programs is not uniform throughout the country. Where massage therapy is regulated, certain parameters are provided legislatively. In regulated states, the range of education requirements vary from 300 to 1,000 in-class hours.

In lesser jurisdictions, cities and counties, it is pretty complex, and even weird. Some cities require as little as 80 hours. This is usually a tip that the massage that is occurring is really adult entertainment. Other municipalities, like Tucson, Arizona, require a hefty 1,000 in-class hours of training.

So when legal requirements for licensure of massage professions are low, schools typically adopt that minimum number of training hours. Of course, there are programs that offer training that exceeds local and state minimum standards.

The current standard utilized by both COMTA and the AMTA Council of Schools is 500 hours. As an

accrediting body, COMTA regularly assesses the profession in order to determine if a shift in the number of total training hours or defined course of study is needed. AMTA is comfortable with the standards developed by COMTA.

AMTA has been focused on standards for most of its 58-year history. When there were few, if any, regulated jurisdictions, membership in AMTA was the lone standard that separated the legitimate practitioner from those doing the other kind of massage. In unregulated areas, AMTA membership is often presented as if it were a credential. AMTA does not view membership as a credential.

AMTA has done the necessary and expensive work that identifies massage therapy as an independent and separate profession with its own unique body of knowledge. This led to the establishment of a credential that is statistically verifiable and approved by an external body that oversees credentialing processes, the National Commission of Certifying Agencies.

In 1990, AMTA initiated the formation of the National Certification Board for Therapeutic Massage and

Bodywork, a separate and independent organization to carry out this work. You will see this credential noted by the letters NCTMB, which stands for Nationally Certified and Therapeutic Massage and Bodywork. NCTMB is our field's one true credential. We call it the big "C."

One of the challenges of being in an emerging professions involves the use of the word "certification." Practitioners use the term very loosely. Most references to certification could be termed certification, with a little "c," and can mean many things. A school training program may certify. You would need to know about the institution and its curriculum to know the value of the certification. Is it accredited and by what standards? What type of accreditation, institutional or programmatic? Is the school operating legally in its jurisdiction?

A political jurisdiction may certify a practitioner, but the question again is what are the standards utilized? Individual educators or organizations may certify practitioners. I can certify you in the Steve Olson method of massage -- $500. This is even more difficult to understand in terms of

validity. So NCTMB is our field's only true credential.

The laws governing massage therapy are not uniform. Currently, there are 29 states and the District of Columbia that regulate massage. Some states regulate massage as a medically-related professions, others as an occupation. Most provide title protection. At least one state has two levels for the profession -- therapist and practitioner.

AMTA's efforts to identify the legitimate practice of massage therapy extend back to 1955. We created a draft legislative document called the Massage Registration Act. Amazingly, AMTA members succeeded in having this adopted in several states, including my home state of North Dakota in 1959. The legacies of these early efforts linger in many jurisdictions.

AMTA's current efforts regarding legislation are supported by our strategic plan. We encourage regulation at the state level. In states that do not regulate the profession, the city and county levels often adopt regulations.

Unfortunately, many of these local laws focus on controlling massage in the context of adult

entertainment, not the legitimate profession of massage therapy. It is strange, but by simply crossing a municipal or state border, you can go from an area that treats massage therapy respectfully to one that mandates a practitioner have a felony check and an annual certification that they are free from sexually transmitted diseases.

AMTA is organized as a national membership association. Our members express their wishes at the state level via AMTA chapters. While AMTA is supportive of state regulation, we rely on our chapters to identify legislative goals.

Therefore, we have a government relations program, we have established a legislative granting process, we offer regular training to our members, we monitor and track legislative bills, we work cooperatively with other associations and legislative efforts and support coalitions between the massage and bodywork practitioners. We provided a forum for the initial gathering of the Alliance of State Regulatory Boards of Massage Therapies.

One of the most difficult aspects of

legislation rests in the area of scope or practice. We have worked diligently to develop language that provides massage therapists with the broadest definition possible. We have had to be careful not to step on toes of other licensed professions and to take into consideration what legislators are willing to accept.

In all cases, we have accepted the political reality that our scope of practice must respect other professions that share all or part of our proposed definition. The latest challenge to the development of scope of practice language revolves around allied practitioners who claim they do not practice massage therapy and wish to be exempted from regulation.

While this further complicates our desire for a clear definition of our scope of practice in the legislative world, we are making the necessary adjustments.

The difficulties include trying to help legislators understand the practice parameters of energetic approaches --

DR. GORDON: Excuse me. You are going to have to end pretty quickly.

MR. OLSON: Okay. AMTA believes that massage therapy is a valuable part of wellness and health that connects mind, body and spirit. Massage therapy is something that is and should be available to all people at all levels of society and practiced in a caring, professional, and ethical manner in order to promote the health and welfare of humanity.

Thank you.

DR. GORDON: Thank you. We will come back to some of those other issues, I am sure, in the question period.

Clem Bezold?

DR. BEZOLD: It is an honor and pleasure to testify today. You have my testimony, which I have written out. I will run through that quickly, and I have also included the summary of our major report on the future of this. I am speaking to you as a futurist. You have, in this topic of licensure and credentialing, a very difficult task. It is very complex. We need it in many ways.

Is it actually protection for the guilds? Licensure I think, historically, in the United States in

the last century was that.

Does it protect? Do our systems of safety and quality assurance protect? Not adequately. So you are faced with the question for CAM.

My input to that, again, as a futurist, and I have worked with NOCA, CLEAR, and a variety of the licensing and credentialing groups. We have worked with several of the health professions over the years, but I am not an expert, as many of the other people testifying. As a futurist, what I would say is, the first thing I would recommend -- this is Page 2 of my testimony -- is that in thinking about quality assurance, as licensure and credentialing does it, you need to think about the larger values of the health system that you would recommend as a commission.

I have listed a variety of values. They are often in conflict, but held by different parts of the health community and the public, and that as you think about those, there are values in conflict, and you should think, as a commission, about what are the values of the health system that you are after.

Second, on Page 3, the issue of holding

accountable individual practitioners I think is very important, and I think that will ultimately and should ultimately be done in a variety of ways, including report cards in practice in communities, and that some of the CAM practitioners that I have worked with over the years are a little uneasy about report cards.

It sounds a little focused and not as noble as many CAM practitioners aspire to be, but the issue is that consumers, in effect, should have some way, as your question, of how do you judge in the local community who is the right massage therapist or the right chiropractor to go to. Generally, you go to your friends and say, "Who do you know, and who is good?" Well, as a futurist, I will say, in the next few years, it will be easier to do that. I will say, in a minute, more about that.

The point here is that individual practitioners need to be evaluated in the context of the health systems they practice in, and since many of the CAM practitioners practice individually, it is the larger system of reimbursement.

The second thing that we, in effect, need report cards on are the different modalities. To what

extent is acupuncture or homeopathy better for "X" condition? As we will see in the years ahead, it will be "X" condition for "X" phenotype or genotype of people. It is complex.

And then finally, quality assurance of specific products. Is that herb, in that formulation, as good as another herb or as good as something else? So just quality assurance has all four of those contexts that you need to think about.

In terms of the future, if you ask me as a futurist, what are the forces that you should consider in thinking about licensure and credentialing, starting on Page 4, there, (1) is genomics and customization. It has been interesting for me, as a futurist, to watch this in conventional health care, and we deal with a variety of the largest health providers in the U.S. and beyond.

Genomics, in effect, is saying we will come to understand genomically related diseases, which are many conditions. We will also understand one estimate that we are using, which is about 10-percent of genes are highly penetrant. If you have a cancer gene, that switch will go on. If you have the cancer gene for the other 90

percent, you need behavioral and environmental factors to go on. So that, too, is complex.

But what was interesting, when we did this report, was customization by genotype will then relate to phenotype, behavioral and physical manifestations of genetic-related differences. If you ask who has been observing phenotypically clinically relevant differences, Aruyveda, Oriental medicine, homeopathy have incredibly involved systems.

So I would encourage you to say that genomics has nothing on many of these systems and that, in effect, in the years ahead what we need to do is think about what are the lessons that you can learn from those phenotypic relationships, both within and across those modalities. But then, in terms of e-health, clearly, and this is another trend.

So customization and genomics are important to think about, and E-health is as well. E-health, for me, includes expert systems, it includes the ability to put knowledge into a clinical decision tree and make that available.

For CAM, where there are dosing questions, say,

homeopathic readings, I think, as a futurist, that you will be able to come up with algorithms. Now, is that the case for post-diagnosis? Potentially. There are areas, when we are taking the chiropractors through this line of thought, they did not like the fact that there may be a robotic chair for manipulation at some point, but as a futurist, I never say never.

The issue for you to think about is, we will be able to decentralize the expertise in many of these fields directly to consumers or to other providers, and that is a good thing. That is a good thing. There will be issues of how well we do it and what qualities do we violate in the process. Those need to be considered, but in general, I think that that will be significant.

The third trend is consistent recordkeeping of electronic medical records, and I would argue that you should strongly come out recommending that CAM providers maintain records for their patients so that their outcomes can be judged with all of the issues around: What are the outcomes and who is judging them, and the fact that, as individuals, we all have slightly different takes on what outcomes mean, and that that should be

factored into it.

But the issue is that all of the health care providers, CAM or otherwise, should be keeping enough information on their practice with their patients to be able to judge outcomes and that there obviously needs to be privacy protections.

What I would encourage you to anticipate is, and in writing this, I hadn't speculated on it enough to know what the right examples are, but are there particular doses or other diagnoses which, if you were an insurer or an employer, you would want to know because you might want to knock that person out of your pool.

Hopefully, we will have antidiscrimination laws passed, but I would encourage you to anticipate what other things, which, as medical records become more ubiquitous, how could you get messed up in terms of that.

The biomonitoring. It is clear that we are going to have wristwatch-like devices that will give significant readings. Now, will it do pulse diagnoses? I don't know, but in terms of other things, we will be able to do very specific tracking, and that that will be put into your medical records.

The widespread use of outcome measures and report cards. I would again say that in most communities we should encourage the development of report cards on local providers to know what their outcomes are and that that is happening, and that health care providers, large insurers, will move in that direction, and that you need to think about, are there positions you need to anticipate for CAM providers on that.

But I would also encourage you to think about broader approaches to quality, and that is, we are talking about quality assurance. Licensure and credentialing are two major modes. I summarize licensure to be a state-sanctioned monopoly given to one type of practice within a scope of practice, to use state powers to keep everybody else out. That is how I summarize licensure.

Credentialing are self-professionally generated standards that professions put on themselves. Both are important, but the issue is that, as we look at quality, there is inherent quality; what is in a pill or an herb, functional quality; does it work. And then, increasingly, there is contextual quality we are putting

into judgments about things; does it protect the environment.

I would argue that, for example, the ISO 14,000 standards are an example of contextual quality standards, significant global standards. CAM providers argue that they are on the better side of the good for much of that. I just want you to be aware of the fact that there is a movement toward broadening standards in that sense, but I would also say even our definitions of health are broadening, and that CAM should take a position on this broader definition of health.

The one that I will use in particular, given this is a White House Commission, is Healthy People 2010 objectives for the nation. The two overarching goals of Healthy People 2010, longer years of healthy life and the elimination of health disparities. I would encourage you, particularly in the latter case, to say what is the role of CAM and what is the role of licensure and credentialing in that regard.

Smarter markets are basically the ability of consumers to integrate larger sets of values with the question that you asked before about, how do I choose a

doctor. Well, I should choose one who I like, not only how well they do with my phenotype in terms of outcomes, and their personal behavior, but whether they support other things in the community that I like.

Finally, e-testing and e-learning and credentialing, the ability to test people. Right now, we use professions like the massage therapists that do significant work in developing a body of tests. In the future, increasingly, we will be able to electronicize that.

So my final summaries are all in here, and with that, I will say thank you.

DR. GORDON: Thank you, Clem.

James Winn. Welcome back, Dr. Winn.

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

It probably will not surprise anyone to hear that I have a slightly different take on licensure, particularly as it relates to physicians. I would say, certainly, that it is a pleasure to come back and be able to visit with you again, and I hope I can provide some further insight into what the Federation of State Medical Boards has currently undertaken in regard to CAM

therapies, and what might be expected from state licensing authorities regarding physicians who choose to use such therapies in their practices.

State medical boards are required by law to protect the public from unqualified and unfit practitioners. They do this by assuring that only qualified individuals are able to render services to the public. They develop rules and standards for medical practice, and they take appropriate actions against licensees in order to protect the public from the unprofessional, incompetent and unlawful practice of medicine.

Now, included in the very many responsibilities of state medical boards to assure effective regulation is the protection of the public against questionable and/or deceptive medical practices, regardless of whether those are considered to be traditional or unconventional, alternative or complementary or any other type.

The proliferation of practices, under the broad rubric of complementary and alternative medical practice and many of the promotions that have been occurring in the United States in recent years, has caused the

Federation and its member boards concern because many of these practices seem to be questionable in that they lack scientific research and clinical validation. Others have been shown to be patently worthless and likely to deceive the public in regards to their health care.

So, in short, some of these therapies may pose a risk to the public's health, safety, and welfare and require the medical board to take actions to prevent that from occurring.

National and state legislative initiatives have been introduced which have caused concern on the part of medical boards because of their potential of restricting the boards from being able to provide appropriate regulation which will allow consumers access to efficacious CAM therapies, but protect them from those therapies determined to be unsafe.

I would point out that there are varying degrees of potential harm that can impact patients who undergo any type of questionable or deceptive form of health care. There is (1) the economic harm, which results in some type of monetary loss, but perhaps presents no health hazard; (2) there is indirect harm,

which results in a delay of appropriate treatment of the condition; and then (3) direct harm, which results in an adverse patient outcome due specifically to the therapy.

The Federation Special Committee on Questionable and Deceptive Health Care Practices was established in 1995 to research, to review and to evaluate the status of questionable health care treatments, procedures and/or promotions and to develop strategies to be recommended to state medical boards for the regulation and the discipline of physicians who engage in unsafe and/or deceptive practices.

The Committee's final report was adopted by the Federation in 1997, and that report strongly supports the concept that the prevailing standard of care used in evaluating health care practices be consistent, whether such treatment is regarded as conventional or unconventional. Such standards would include appropriate documentation, informed consent, appropriate monitoring and follow-up, rationale for treatment and periodic review of the efficacy of the treatment.

The criteria used to evaluate health care practices and whether or not a licensed physician is

practicing medicine in an acceptable manner would include the following types of criteria:

Has an adequate patient assessment been conducted to determine that the patient has the condition for which the treatment is being prescribed;

Is the methodology promoted for the diagnosis as reliable as other available methods of diagnosis;

Is the risk-benefit ratio greater or less than that for other treatments for the same condition;

Is the treatment based upon competent and reliable scientific evidence, including properly conducted clinical trials and/or is it supported by a scientific rationale;

Are the practitioner's promotional claims supported by competent and reliable scientific evidence;

Is there a logical and reasonable expectation that the treatment offered will result in a favorable patient outcome;

Is the practitioner excessively compensated for the service provided; is the benefit achieved greater than that which could be expected by placebo alone;

Has the patient's informed consent been

adequately documented in the medical record.

In order to effectively process a complaint or a report received by a medical board involving questionable or deceptive health care practices, state boards must determine whether or not the practice in question is (1) indicated; (2) appropriate; and (3) reasonably safe, as compared to established treatment models.

Research indicates that only four medical boards currently have adopted CAM policies to assist them in determining whether or not specific medical practices constitute a violation of the state's Medical Practice Act, Illinois, Kentucky, Nevada, and Texas. The remaining states have no formal policy or guidelines currently in place, and, instead, deal with complaints involving CAM issues on a case-by-case basis.

Therefore, medical boards would obviously benefit from guidelines to help them assure that the provision of CAM services is based on appropriate and competent standards of medical practice.

Accordingly, the Federation is developing model guidelines to assist its member boards in communicating

their expectations to physicians who are engaged in a practice environment offering both conventional and alternative forms of treatment, or engaged in cooperative therapeutic relationships for their patients' benefits with non-physician, licensed alternative health care providers.

Standards which will be established in these guidelines will include, but will not be limited to, the need for adequate patient assessment, scientific evidence supporting the treatment, a favorable risk-benefit ratio, informed consent, including documentation that the risks and benefits have been disclosed to the patient and, of course, periodic review of the patient.

Through the development of the proposed guidelines, the Federation seeks to establish consistent standards for regulating the use of CAM based on existing guidelines and current research data, thereby providing guidance to medical boards, and licensees, and the public on how to utilize CAM in a manner consistent with safe and responsible medicine.

We hope to promote a nonlegislative approach to regulating the use of CAM therapy, thereby enhancing

state medical boards' authority to provide appropriate regulation and by allowing consumers access to legitimate medical uses of CAM therapies, while preventing the proliferation of health care practices that may be potentially harmful and are deceptive.

To ensure that the guidelines will be comprehensive in scope, the Federation has been blessed by the help of consultants with expertise in CAM. Dr. David Eisenberg, Dr. Russell Greenfield, Dr. Ken Pelletier have all agreed to assist us in this effort.

In conclusion, although some CAM therapies may be beneficial, and many are showing that to be the case, and therefore those that look to be beneficial warrant further investigation and integration into mainstream medical practice, the safety has not been established for many other modalities due to the lack of reliable scientific evidence and clinical validation.

Therefore, the Federation supports the development of controlled clinical trials to evaluate the efficacy and safety of these therapies, as well as information sharing and educational initiatives to further enhance the awareness of the benefits and/or

risks associated with such therapies.

The Federation also recognizes that the scope of this issue reaches far beyond the jurisdiction of state medical boards. Therefore, we are committed to collaborating with members of the medical profession and other agencies and organizations in promoting and supporting research and educational efforts to identify and eliminate questionable and deceptive health care practices, whether they are traditional or alternative, and those practices that are adverse to the public's health, safety, and welfare.

There were about four issues that were given to me, questions, I might touch on and go a little further in the question and answer part of this presentation. One question was should there be condition-specific and modality-specific practice guidelines for CAM and why or why not, and who should be developing such guidelines?

As I mentioned, the Federation is developing these guidelines for use by medical boards so that they can inform practitioners that are their licensees what the expectations are. That could be summed up, I think, in the words that all physicians are expected to practice

good medicine, regardless of what form of therapy that they use. There will be some condition-specific guidelines, such as we have done in the past, on the treatment and management of chronic pain.

There was a question about the impact of integrating CAM with conventional medicine with regard to the standard of care. As I mentioned before, that standard of care should not change just based on the therapy.

The investigative process applied to allegations of professional misconduct will be the same investigative processes applied to any other allegations that are received by the state medical board. The guidelines, I think, will ensure that practitioners in fact understand the expectations and are able to meet those expectations without undue concern that the medical board will charge them with unprofessional conduct based solely on the practice or the use of CAM therapies.

Thank you very much.

Panel Discussion

DR. GORDON: Thank you very much.

Questions? Tieraona first, and George next.

DR. LOW DOG: I promise to behave.

My question is simple. Thank you for all of your presentations. This is for Mr. Olson.

Bless you, massage therapists, first of all.

Second, do you think that licensure or membership in the AMTA and all of your hard work on education, has that helped or hindered your profession? And if so, or if not, why?

MR. OLSON: I think it ultimately has helped us very well and served us well. We are in an odd position, in that our name is oftentimes used by the world of adult entertainment. So we have had to go the extra mile to convince the public and the legislatures that the word "massage" doesn't always mean prostitution. So we are kind of in an unusual position, but we have really turned things around.

Some of the data I delivered, in terms of the increase in the number of people receiving massage, the growth in the profession, we are just tickled with events of the last few years. I think a large part of it is the fact that we keep our education standards adequately high for the profession.

DR. GORDON: George, and then Linnea, Effie, Tom, and Charlotte.

MR. DeVRIES: Mr. Olson, when, say for example -- and this is really, what does the AMTA recommend regarding licensure and education -- if a state legislature were to call you and to say, we are considering statutes for licensure or non-licensure of massage therapy in our state, what do you recommend to them regarding licensure and education?

MR. OLSON: Well, I was not able to complete my full presentation, and I apologize for that, but it is in your documents. On a strategic planning level, we do support legislation in all states for the profession of massage therapy. However, we are organized as a national association. Our members express their voice locally in our chapters. So we acknowledge that our chapters are the ones that kind of lead us at that local level. So, typically, we work through our chapters in this legislative world at the state level.

I alluded to the fact that we have gone to great lengths to assist chapters legislatively, and so we have legislative models. We also have city ordinance

models that we can plug into virtually any jurisdiction.

Does that get close to answering the question?

MR. DeVRIES: Yes. I guess I am looking for, do you hold a standard which, ideally, you think should be a higher standard, you are advocating licensure in every state, not regulation or certification by municipality or town, and that you are really advocating the higher standard?

MR. OLSON: We will take the highest ground we can, but we will also deal with the political jurisdiction. We have many forces to deal with, not only licensed professions like physical therapy, but we have other areas within sort of our bodywork field, like the Oriental bodyworkers and Asian bodyworkers, energy workers, movement modalities, Feldenkrais, Trager.

So we were having more difficulty writing scope of practices these days because of all of these different bodies that are coming forward. So we don't say no to anything. We are sitting at the table. We are ready to negotiate. We are going to keep improving our standards and getting our standards up to the highest professional level that we can, and we want to sit down at the table

with people who are doing the same thing.

Thank you, George.

DR. GORDON: Linnea, Effie, Tom, Charlotte.

MS. LARSON: Real quick, Mr. Olson, do you or your members take a position on other practitioners, such as those who perform reflexology or Reiki or energy, and make a requirement that they have to have massage training in order to do those practices?

MR. OLSON: Many of our members use Reiki, many of our members use reflexology, many of our members do energy work. So we sit in kind of a funny world, where those approaches are folded into our members' practices.

It really comes back to the local legislative work again, where our chapters work within their jurisdictions to try and sort these matters out. We are not out to harm anybody else, in terms of restricting their ability to carry out reflexology or to practice Reiki, but all of these things are determined politically at the state jurisdictional level. We regularly establish coalitions and invite people into the conversation.

So I can't say we have a statement that would

prohibit people from doing those things in jurisdictions that are licensed, but we do want to talk with people and have them involved in coalitions. If they want to be opting out of any licensing laws, we will help them, but they have to come to the table to talk.

MS. LARSON: So, in a way, are you advancing that the massage therapists actually are the organization to negotiate with, with all of these other practitioners?

MR. OLSON: We typically have the largest representation in a jurisdiction. We typically have more money than other groups, and we are trying to use that wisely and kindly. We are kind of the focal point. We work in coalitions where we are not necessarily the leader of the coalition.

So we shape coalitions, the coalitions elect their leadership, we oftentimes contribute to the lobbying aspect of that group.

MS. LARSON: In short, it would be a state's rights issue, and you would promote, at some level, that massage therapists would corral all of the other practitioners, but it would be decided state-by-state?

MR. OLSON: I wouldn't say massage therapists

would "corral" everybody, but we would sit at the table with everyone cooperatively.

DR. GORDON: Effie, and then Tom.

DR. CHOW: I have just two questions, one simple one, to Mr. Olson.

Do you work with NCCAOM, who also has the bodywork credentialing for Asian bodywork?

MR. OLSON: That is a new credential. We are well aware of it. We have a relation with the association AOBTA that has been working with that exam, the Asian Bodywork Association.

So we are well aware of it. Yes, we are looking at that exam, and we think it is going to be a very good addition to the field of bodywork.

DR. CHOW: Good. Thank you. For the other two --

DR. GORDON: Effie, can we just have one question because there are a lot of people who want to ask. We will come back to you later. Sorry.

MR. CHAPPELL: Thank you. My question is of Dr. Bezold.

I think I heard you say credentialing is

something that is a self-standardization process within a professional group and licensing is more a state-defined status. Is technology fragmenting professional life, and is the futurist view a fragmentation of professional life? And in such a fragmentation, where would you put your confidence?

Let me give you some options: branding professional groups, like AMTA as an example, state government or federal governments. Where would you place --

DR. BEZOLD: I would say some of the above in this mix, in that I would argue that what you want is a marketplace where consumers can effectively choose on the basis of identified quality and known evidence, and the fact is we don't have evidence on most practitioners at the moment.

MR. CHAPPELL: Right.

DR. BEZOLD: And that branding, in that sense, becomes --

MR. CHAPPELL: They are branding.

DR. BEZOLD: They are branding, but they are also trying to, in effect, use regulatory powers to say