that, in other words. That is a claim, and professional associations make that.

If I take a consumer perspective, the question is, can anyone tell me whether the outcomes are any better if it is done through the massage therapists versus some other group?

And so, I would say that at various times I thought that national certification, which some groups have, and potentially nationally licensure, would be a good thing where there is a modality that is uniformly practiced. The dilemma is that it is much more complex than that, and modalities fray at the edge.

You asked whether technology is, in effect, fragmenting, and it clearly is, and it will become more so. Yet, many of the modalities have an internal coherence, which you have to rise up to appreciate and hold. They rightly argue that they can certify who rises up and holds that integrity. Things will get more complex.

MR. CHAPPELL: Could we have Dr. Olson comment on that as well? Thank you.

MR. OLSON: I am not a doctor, but --

MR. CHAPPELL: Sorry.

MR. OLSON: I think Clem really did a nice job. Is there something particular you would like to hear from the world of massage?

MR. CHAPPELL: Do you see an increasingly fragmented range of services over the next 10 years? Or, 10 years from now, do you see the focus of AMTA having greater or less relevance to the profession?

MR. OLSON: I am going to answer by going back to 1990, where there was more of a cohesion within the massage and bodywork world. At that time, when we established national certification, everybody wanted into national certification and into licensing. Since then, we have seen the fragmenting occur. People want to go in different directions now. They want to be exempted from licensure.

MR. CHAPPELL: Exempt from licensure but not credentialing.

MR. OLSON: Some of them want to establish their own credentials, like the NCCAOM exam for bodyworkers. So they are trying to do that.

Now, that exam is very expensive compared to

the national certification exam for therapeutic massage and bodyworkers because it serves a lower number of people. So they are trying to institute some of these certifications.

I think there is going to be a closing in again. I think there will be uniting of the professions, and we are going to find a way to do that. I don't know the answer, but I think this body is part of what is going to bring it there.

DR. GORDON: I have Charlotte, Wayne, George Bernier, and Don.

SISTER KERR: Dr. Bezold, I was a little bit surprised to hear such an emphasis in your visioning for the future in terms of high tech. At least, I was wondering, because of CAM there seems to be, in my opinion, an emphasis on high touch/low tech.

You spoke about the values driving the system, where was the caring component emphasis. Some of us feel that life is a mystery to be lived and not a problem to be solved, and I did not hear that emphasis in your futurist presentation.

DR. BEZOLD: In terms of individuals or

practitioners sort of living or practicing in a higher touch reality or situation, I am all for that. The question is, in terms of credentialing and licensure, the issue of the day, what is the context for doing that?

For me, part of the big context is, we have a system, very elaborate systems of licensure and credentialing, that if you ask, what is the failure rate, they are relatively high. If you ask, can consumers choose effectively, they can't choose very well.

In that context, the technologies that I see may be helpful, with the caveats that, in terms of the integrity of practice, in terms of the relationship between the practitioner and the individual, some of those may not be very well captured in terms of outcomes.

But in the marketplace, and what I didn't get into was the public policy justification for licensure is market failure, I would argue that, in general, what we should try to do is make markets work, give consumers the ability to choose effectively and wisely what they want. We don't have that now.

Adam Smith defined a market as producers having equivalent power to consumers and vice versa. In that

arena, we don't have markets, but we are approaching a time when we may.

DR. GORDON: Wayne?

DR. JONAS: Dr. Winn, it appears to me that there has been a trend towards trying to get a number of nonstandard, unconventional types of practitioners that physicians deliver classified as experimental under IRBs that are set up, and this type of thing.

I am just wondering, is this of concern to the Federation, and have they been looking at this or thought about how to address this in some way?

DR. WINN: I think the answer to that is, it concerns us if they are just labeled experimental, without going through the process, as you mentioned, of having institutional review boards and so forth, that, in fact, are there to advocate for the patient so that these treatments are not fostered upon people who don't understand that they are being subjected to an experimental therapy.

So, in the context of the Federation, our focus is really to make certain that patients, if they are taking a risk, that they understand that risk, and they

understand that less risky therapies are, in fact, probably not of any advantage to them, that their advantage lies on the experimental side or that there is very little risk in this experiment.

They may have a condition that doesn't threaten their life or is of no great concern. Let's take an example of hay fever -- troublesome, but probably very unlikely to cause problems unless associated with asthma or so forth. They may choose to say, well, I am willing to accept this therapy, knowing that it is probably not going to hurt me, and I might find that it helps me, but I am doing it with my eyes wide open. I know what the doctor is engaged in.

Also, there is also this sort of side of ethical behavior on the part of the physician in that a physician should say, "You are part of a research study. I am receiving funds for this research study, and therefore you are enrolled in this at no cost."

I think it is troublesome if you have a doctor who claims that they are doing research, and at the same time, if you ask the patient, they have no clue they are part of a research project, and they are paying good

money out to the doctor for that therapy. So those are the kind of behaviors that we would be particularly concerned about.

DR. JONAS: I guess I am concerned about IRBs that are set up precisely to be kind of umbrella organizations to say, yes, we are doing this in the context of an experiment, when actually their real motivation is to simply provide the therapy.

DR. WINN: We would view those kind of things as being fraudulent because that is not the real purpose, and so we would take a very dim view of an IRB that was, in fact, just a sham.

DR. JONAS: Right, but that would not be within your jurisdiction to judge, that would be FDA or some other group?

DR. WINN: Although we could, in fact, through the licensing board. You know a doctor's privilege of practicing medicine subjects them to broad evaluation of professional conduct, and the doctor who knowingly enters into a process of approving therapies that he or she knows not to fall within the context of what they are supposed to be doing, we would consider that to be an

unprofessional act.

DR. GORDON: George?

DR. BERNIER: I have a question for Dr. Winn. In your concluding remarks, you said that "The Federation also recognizes that the scope of this issue," that is, the risk-benefit one, "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."

If you were to be a futurist, what would you see that collaboration -- how would you see that being played out?

DR. WINN: I think that collaboration certainly could involve not only the medical profession, but other professions. For instance, if the massage therapy is, in fact, believes that a certain condition could be treated safely, more effectively and at less cost through their therapy than other conventional therapies that physicians might offer, then I think it is appropriate that we encourage research into that area so that doctors that we license could, in good conscience, say, I don't have the

skills and the techniques to treat that problem with my therapies. I would refer you to somebody who I know is competent to do that. And that referral would be appropriate, and it would not subject the physician to scrutiny by a licensed authority as being inappropriate or placing the patient at risk.

So I think we have to find out what kind of therapies work and who is best trained and qualified to deliver those therapies. Unfortunately, what tends to happen is people who have one hammer, you know, then everything looks like the same nail. And so consequently, if you are in one area, then you sort of start pushing those boundaries and say, well, we can treat this and we can treat that, when the fact is there is no proof that those therapies would be efficacious for that condition.

DR. BERNIER: Thank you.

DR. GORDON: Don?

DR. WARREN: Well, this is kind of confusing a little bit. I am a dentist, and I am going to ask Dr. Winn a question.

A couple of years ago, maybe three years ago or

four years ago, there was a meeting held in Fort Worth, Texas, that dealt with the FDA, the state attorneys general and the state boards to aggressively go after CAM practitioners. Is your group part of that? If it is, what about the 52 percent of medical diagnoses that were reported to be incorrect, do you go after those practitioners for making a misdiagnosis?

DR. WINN: Let me try to break that down. If you are talking about a meeting that was held in Dallas several years ago, not Fort Worth, I am trying to think of the acronym, but I think it is the group of attorneys general, National Association of Attorneys General, NAAG I think is the organization.

[Laughter.]

DR. WINN: And NAAG asked us to help participate in the forum, and it wasn't so much to go after practitioners of CAM, but to go after people who were basically, under the rubric of CAM therapies, fostering unsafe or deceptive-type practices, where they were promising things that were not true, where the public was believing that they were getting some benefit they would not receive and so forth.

I think I would have characterized it more as a discussion of where those efforts should go, if they should go at all. I think it was an educational effort on the part of NAAG and the participants in that regard.

Now you asked about incorrect diagnoses. I am unfamiliar with the study that you are using to say that 52 percent of all diagnoses are erroneous.

DR. WARREN: It is just one of the few things that I saw in JAMA that reported that 52 percent of all medical diagnoses were incorrect, and the inference was that 52 percent of all therapies rendered were incorrect. So I just wondered --

DR. WINN: My response to that was that any practitioner who demonstrates a pattern of not meeting the standard of care of doing the proper diagnostic tests, the proper examinations, and following up with appropriate therapies is subject to evaluation and possible discipline by a medical board for putting the patient at risk. So, yes, the answer is if medical boards know that doctors consistently engage in substandard care, substandard practice, which I would assume somebody who misses 50 percent of the diagnoses

and institutes the wrong therapy, if that came to my knowledge, I would question that. So I think the answer is correct.

DR. GORDON: Dr. Winn, one of the issues that has come up, both here, but especially as we have gone around the country and done Town Halls, is physicians have come and testified before us who have said that state medical boards are calling them up on charges, even though there have been no patient complaints, even though there has been no demonstrable harm done, even though there have been no false promises.

I know this is an issue of concern. We heard three physicians in New York State, we heard about the case of Dr. Sanaiko, both in California and in Washington State, where even in California, where the California Medical Society testified on his behalf, and he was doing kind of allergy and food elimination therapy for attention deficit hyperactivity disorder.

So there are real concerns out there. And I appreciate what you are doing and what you are doing bringing people who are expert in CAM into the decision-making process, but I am wondering what the Federation is

doing to take a closer look at what at least seem to us possible abuses in terms of the disciplinary system.

DR. WINN: Let me try to answer what seems to be several different questions that you have posed. Number one is I think the guidelines that we were trying to develop now will go a long way in both educating members of state licensing authorities and putting the doctors at ease that this is the expectations. If you know what you are expected to do, then you can achieve that. If you are concerned that I don't know whether I should be doing this or not because I don't know whether the medical board would view this as favorable, it discourages doctors from going forward in an appropriate way and using new therapies. So I think that that is going to be a big effort on the part of the Federation.

Now, it is not only patients that complain, but practitioners complain. Other physicians, nurses, other types of practitioners have lodged complaints with state medical boards. Insurance organizations may lodge a complaint with a state medical board because they are being billed for these kind of services, and they believe that there is some question about those. Medical boards

get complaints from different sources, other than just the public or the patient, and they are obligated by law to investigate those complaints.

So when you say "being called up on by charges," my sense is that there are not very many people each year that are called up specifically on charges that they engaged in CAM therapy, and I have data that would pretty well back up what I have just told you.

Would they be investigated? Yes. If a complaint comes to the medical board, they are obligated, by law, to conduct an investigation to find out what that -- so some doctors assume that, well, I am being investigated, I am in trouble, when the fact is, it is only because a complaint has been lodged against him, and the board has no other recourse, except to at least open up a preliminary review.

Now, in regard to what frequently happens I think is that -- and I don't want to talk about the specific cases that you are mentioning because I have limited knowledge of some of those -- but frequently it is not the fact that they used a certain therapy or took care of certain type patients, but that in doing so that

they had disregard for basic principles of medical practice and standards of care.

So it doesn't excuse an individual, just because they have chosen to use an alternative therapy, for making certain that that patient is being observed, followed up, and if the therapy is not working, that it is changed or further evaluations made.

Frequently, what we have are cases -- I can remember one case where the doctor was concerned that the board was being overly harsh because that he engaged in an alternative therapy, but, in fact, the problem was there were a couple of patient deaths while this doctor was absent and had turned over the care of the patients to just basically a layperson that he had trained. So, consequently, the charge there is really that you have not provided the oversight, not met the standard of care, and you were in Europe when your therapy was being provided to the patient, and there were, as I said, some patient deaths.

So that is the kind of thing I think that we are seeing the boards taking action against. It is really easy when you are going out to the public, and you

are trying to defend your actions, to sort of blame it all on that they are prejudiced or biased against the type of medical practice that you have engaged in.

Does that mean that all of the medical boards are educated, as they should be, in CAM therapies and what is to be expected? No. I think that you are going to see some differences from medical boards to medical boards.

Part of the work of the Federation is to raise the level of education of board members about these therapies. That is why, in my presentation, I said we believe that there should be further research done and further delineation of those therapies that are considered to be efficacious or at least not harmful and a certain realization that just because something is labeled "CAM," doesn't make it, I guess, doesn't insulate the doctor from meeting the standard of care.

DR. GORDON: Is there any way that you think that we, as a commission, can help -- you are helping us understand your process -- is there a way that we can help you with your efforts to enlarge the understanding of CAM in state medical boards?

DR. WINN: Certainly, I think the provision of information, as to your knowledge of those kind of therapies and practitioners that render such therapies that would be efficacious and for what conditions that they are effective, would be of great benefit, and the reasonings, for instance, of why you have reached that conclusion or what the research studies and so forth are. So all of the information we can get about that would be very helpful.

DR. GORDON: Great. One thing you said really heartened me, that there are some therapies -- several things you said, but one just recently -- you said that there are therapies which, as long as they are not harmful, and there is no pretense that they are any more than they are, that you would not immediately see those, even though they are not the standard of care, which of course, is always changing, that you would not immediately see those as cause for investigation or for concern.

DR. WINN: Yes. I think that certainly a therapy that the patient knows probably has very little benefit, and the doctor believes that it to be not

harmful, I don't think that the boards are going to spend a lot of time chasing that kind of situation.

I can give an example from my own days of family practice. I had patients who came in who wanted a B-12 shot, and they would say, "You know, this seems to perk me up and everything."

I would tell them, "I don't have any reason to think you need B-12. There is no evidence you have a deficiency, and I don't think that there is any indication that this really is going to do that. If you understand that I am not prescribing it for you, I think it is relatively harmless," and so with that understanding with the patient, then it was administered, but I didn't turn around and bill the insurance company for a B-12 for some pernicious anemia or something else. That clearly would be a fraud.

So I think there are those kind of situations that there can be a trade-off in what the doctor is using.

DR. GORDON: I don't know if you know, there was a very interesting paper in the "New England Journal" about 10 years ago, and I can get you the reference, with

people with normal B-12 levels who had symptoms of B-12 deficiency. So you may have been, really, a major help to --

DR. WINN: Well, that is true.

[Laughter.]

DR. GORDON: And the symptoms went away when they got B-12 injections.

I just have one quick follow-up for you. We talked last time about chelation, and one of the things that you said to us, which we really appreciated, was that you were open to the creation and the collaborative working, you were open to working collaboratively with people who wanted to do legitimate chelation studies.

I am wondering, has that moved ahead at all? Where are you with that?

DR. WINN: We continue to support that quite strongly. The fact is our committee again made a plea that those studies move forward. Dr. Eisenberg also has been trying to get some grant money and get the government interested in doing those studies.

So, at this point, I don't know that I can tell you that any progress has been made since the last time I

was here, but we continue to welcome the integration of people because, I think, as I said before, that in order for the study to be recognized by all parties, you have got to have people who do this on a regular basis buy into the study and say, we want to make sure this is done correctly, because otherwise you end up with charges, well, those guys did the study, but they don't do it normally, and so they don't know how to do it just right.

DR. GORDON: Right.

DR. WINN: And our point is that we want good, solid information, one way or the other, and I think that the people and the public really demand that.

DR. GORDON: That is great.

Have Drs. Bruce Dooley and Tammy Borne [ph] been in touch with you about this? Because they have been in touch with us several times.

DR. WINN: About the study --

DR. GORDON: Doing a chelation study.

DR. WINN: I haven't had any direct communications with Tammy. She is the chairman of the Michigan Board of Osteopathic Medicine, I believe. In that regard, I do interact with her and her board from

time to time, but I don't recall a direct communication to me for --

DR. GORDON: I will just remind them of this because I heard you pretty clearly last time.

DR. WINN: Absolutely.

DR. GORDON: I am really glad to hear this openness.

We have a couple minutes more. Are there any last questions?

Yes, David?

DR. BRESLER: Just again for Dr. Winn. For a period of time the FDA, in terms of the food manufacturing industry, developed a grass list of substances that were generally recognized as safe, and this was a broad consensus amongst their industry, and kind of side-stepped a lot of regulation on some of those substances because they are so widespread, so widely used.

Is it conceivable that following some consensus meetings or other things, that there would be some of these CAM modalities the licensing boards would generally recognize as safe and sort of focus on those that were

much more questionable?

DR. WINN: My answer to that is I would expect so. I think if you had legitimate bodies who have studied the issue come forward and say, these are widely accepted, they appear to have benefit, there is no reason to suspect they are harmful, then I think that the medical boards are going to say, okay, that there is no reason for us to spend our time and energy chasing something that is not hurting people and can wait until which time that they are found to be efficacious and totally integrated or not.

DR. GORDON: Thank you. Thank you very much, Dr. Winn, and Clem Bezold, and Steve Olson.

Did you want to ask a last question?

COMMISSION MEMBER: I just wanted to say that if there is a way in which a federal panel like this can be involved in assisting with some of the states' issues, one of the ways would be to stay in close contact with these overall guidelines that you are trying to provide for the states so that we can at least be cognizant of those and consistent with some of those.

DR. WINN: I will be happy, as we move along,

which I expect those guidelines to start taking pretty good substance in the next six months or so, to try to send you a draft for your comment, if you would like to do that.

DR. GORDON: That would be wonderful. We really would appreciate that. Thank you all very much.

Rather than break at this moment, what we are going to do is, I am going to give you our charge -- how is that for a word -- our charge for the rest of the afternoon and tomorrow, and then we will break and go to the separate rooms. Everybody else is, of course, invited to listen to us as we get our charge, so to speak.

The remainder of the work that we are going to be doing is building on what we have heard so far today, making use of the documents that have been provided to us by 150 different organizations and individuals. We are going to be meeting in small groups.

All of you know which small group you are in and who is the leader of the small group. The four small groups are going to meet and discuss the three areas that we have been considering today in order.

So the first area we will discuss will be the issue of undergraduate and postgraduate education, then continuing education, and finally credentialing and licensure. Each of the meetings in the group will be for an hour and a half. Toward the end of that meeting, the charge of the group leader is to get recommendations from the group.

Now, one more word about the recommendations. These are not final recommendations. These are what are coming up from your discussion. What we are going to do, after we have finished with the three breakout sessions, is, tomorrow afternoon, from 12:30 to 4:00, we will have reports on each of these aspects, that is, undergraduate and graduate education, continuing education, and credentialing, from each of the groups.

We will put up the recommendations, the concerns, the considerations, on the board, and we will have a discussion about them. We will discuss each segment in turn. And so, at that point, people will be able to raise all kinds of questions. Remember, we are not coming to final conclusions today, but we are moving closer to our recommendations.

What we will do today is just come back here. We will have about a 10-minute break, and then we will come back at 5:45 here, and we will just hear for a couple of minutes from each of the group leaders just to see how things are going and if there are any adjustments that we need to make. We will just do that for 15 minutes, and then we will break for the day.

We will come back tomorrow morning. Instead of meeting here first thing tomorrow morning, we will be having the group sessions at 8:15 to 9:45, and then as you see on the schedule, a break, and then Breakout Session III, then lunch break, and then coming back here at 12:30 for the full panel and the full three and a half hours of discussion.

I am going to read off where the different groups go. Any questions about that at this point?

[No response.]

DR. GORDON: Okay. Great. We will be having some dinner together, an informal dinner.

Discussion Group No. 1 is in Room 405-A; No. 2 is 505-A; No. 3 is 640-H; No. 4 will be right here in Room 800; and then Michele and Steve and I will be in

Room 634-F.

So, at least for the first 45 minutes, any of you who are interested in meeting with us, are welcome to come. You are all invited to come to the small group meetings.

COMMISSION MEMBER: Can you identify the final subjects of our group here, Breakout Session I?

DR. GORDON: They are all covering the same topic.

DR. GROFT: They are all going to cover the same topics. It is just that some groups will be emphasizing one thing or the other in the three sessions. What you can do is just look in the back of the room. We posted the organizations who responded or who we asked for a response. You can look on the sheets and see which group goes where. So if you are interested in the massage therapy group or the bodywork, they may be in one group. So look down the list and then go with that group.

DR. GORDON: But all of the groups are responding to similar questions, all of the four groups, but the information, the input of information is from the

many, many groups that are up there on the board. Okay?

Once again, tomorrow morning, at 8:15 or so, we will also be going back to the small groups. And again, Michele, Steve and I will be available in 634.

So we will see you all back here at 5:45.

[Whereupon, at 4:10 p.m., the full Commission was recessed to reconvene the following day, Friday, February 23, 2001, at 12:30 p.m.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE: White House Commission on Complementary and Alternative Medicine Policy

HELD: February 22-23, 2001

were held as herein appears and that this is the official transcript thereof for the file of the Department or Commission.

DEBORAH TALLMAN, Court Reporter