groups for integrative medicine, if you will.

One of the issues that kept recurring was, well, gee, there is no approval for CME for these or I am at risk for getting my license removed, and this type of thing. In fact, I will read you the American Academy Family Practice's draft, which was approved actually.

The first part is rather long, but basically says what we said in the first part of this section, which is programs should -- this is specifically CME -- should present philosophy, efficacy, safety, scientific basis on one or more types of complementary and alternative medicine.

They agree that this should be done. Sponsoring organization may be asked to provide individual topic objectives, individual topic abstracts, faculty credentials to help clarify program content and intent.

Programs should provide evidence-based outcome studies if in existence, published in peer-reviewed medical journals that substantiate these aspects about the complementary and alternative practices in the program. So far so good.

Item 2 is by neither design nor intention will the program promote to physicians, nor will it teach physicians how to use a particular type of complementary and alternative medicine practice.

In other words, we can give you information about it, but nothing else. This is problematic. I mean if something has proven to be safe and effective, then, a patient advocate role would be to say how do I learn about it, at least how do I find out about how to appropriately arrange it for my patient.

Now, obviously, if it is not proven to be safe and effective, you want to guard against programs that are doing that or they are promoting things that have not been proven to be safe and effective or have been proven not to be safe and effective, which are two different items.

So, in grappling with how to address this, we felt like we need some -- the groups that are responsible for regulating continuing medical education in these areas should come together, perhaps with members of the Commission, with each other, with professional societies, and come up with some reasonable guidelines for

addressing issues of use and skill. The knowledge issues are not so much of a problem, but we really need to address in a more I think comprehensive way the delivery of integrated practice.

DR. GORDON: Great. I see heads shaking. Is there general agreement about this, that this is a recommendation that we would make, to shift and to include use and practice, as well as theory? And then of those techniques for which there is evidence of safety and efficacy.

DR. FINS: Wayne, could I just ask you a question? Is there an incremental way to do that? I mean that statement from the American Academy of Family Practitioners, would that preclude a family practitioner taking a course somewhere and then getting credit as a family practitioner for his or her continuing certification?

In other words, is there kind of a firewall, like you don't have to endorse it, but you could -- could you clarify that a little bit?

DR. JONAS: There actually is, and this is where the Federation of State Medical Boards, which does

not approve CME, comes into play, because they do approve practices in each of the states -- I am sorry -- they do approve licensing in each of the states, and most of the professions require some type of continuing education to maintain their license, and it has to be usually a certain percent in what we call Category 1, which is the highest level.

The Federation has said, well, okay, we will approve things to try to get around this issue, because it is very difficult to determine what is information, what skills, when it is not. I mean this is not an easy thing to do, you know, even if you think it ought to be done like this.

But the Federation has said we are only going to approve licensing if you have Category 1. So, then, one of the suggestions was -- and I don't know if this came through and was finally approved -- was that if a CAM practice does not meet these criteria, if it is skills based, we will give it a Category 2. That way, it is getting CME, you can count it, but you have a bit of a problem in a state if that requires that.

So, then, the Federation needs to be involved

in this discussion in some way in terms of how to address the issue of use and skills training.

DR. GORDON: Tieraona.

DR. LOW DOG: I think the heart of this is again this arbitrary, a line that the medical profession uses in this very arbitrary way, of complementary medicine. Again, I think an example is something like glucosamine which many people are familiar with, where we have a meta-analysis on it, and now we have a multi-year study that is published in Lancet showing that, for the first time perhaps, we have a relatively safe and nontoxic disease-modifying agent for osteoarthritis.

Now, at what point is that complementary, because it is over the counter, you can get it at the health foods store, you don't need a prescription? So, as a family doc, if I am there and I am taking my course, I can't learn about glucosamine, I can't prescribe it?

That raises a lot of issues, and I do think that that is why some of these examples may be good actually when we are discussing with them, because it shows to the point how ridiculous some of this is.

And would I be in trouble actually, as a

physician, if I knew there was a safer remedy, and I prescribed a more toxic one that caused you harm, and I didn't prescribe the safer one?

DR. GORDON: When it comes to the issue of education, another example is if you are teaching mind-body approaches, it is okay to quote the literature, it is not okay to teach somebody how to use the approach, not okay to teach a relaxation technique, or it's okay, you just don't get credit for it.

So, I think that if we want, we can certainly make the kind of statement that Wayne was suggesting and perhaps I was suggesting in my questioning of the continuing ACCME.

DR. FINS: Maybe we can ask those entities that provide CME credit to have representation of CAM practitioners when assessing CME for those kinds of activities and also to look at inconsistencies in grading, just to have them again using the model that we have adopted uniformly here, let the entities that do the work figure out ways of remedying the illogic that Wayne just pointed out.

DR. GORDON: We can make statements at every

level. That is another level, recommending that this artificial barrier be lowered or removed is another level, so those are two separate but related recommendations.

Tom.

MR. CHAPPELL: My question is allied with continuing education, but not specific to it, so I will raise it when you are through talking about this subject.

DR. GORDON: Okay. Wayne, do you want to say some more?

DR. JONAS: Michele just pointed out to me that actually there is three kind of things that might go into the development of these guidelines again for approval, how do we deal with things that have been proven to be safe and efficacious, how do we deal with things that have been proven not to be safe and efficacious, and the biggest category she pointed out, which is those things in which there is inadequate data.

DR. GORDON: Right. Do you have any thoughts you want to share now or should we defer this until later?

DR. JONAS: I thought the suggestions that were

made, and, Joe, about bringing some of these groups together that are doing this, these regulatory agencies together, because as we heard, they are already working on guidelines and have been working on guidelines, but specifically to try to clarify the whole issue of the use and delivery for licensed practitioners.

DR. LOW DOG: Can't there be a statement that -- I mean we can gently suggest, recommend -- but I mean can't there be a statement, if there is evidence that something works, there is evidence, and it is safe given that there is no such thing as safe, there is a low risk of toxicity compared to other trials, shouldn't that just be -- why is that kept separate I guess is my question, and can't there be some sort of language that says that that should just be adopted in?

DR. GORDON: I think the answer is what we can do is we can craft some statements that will then come back to the whole group for the discussion of final recommendations based on this discussion.

The question I have now is are there other perspectives on this particular issue that anyone would like to share. Yes, Joe.

DR. FINS: I think they should have an evidence-based, ethical justification for their grading system, and it has to be consistent. If they want evidence based, then, they should provide evidence for the rationale for internal consistency.

DR. GORDON: Any other comments on this particular issue? Okay. Tom, you had another issue.

MR. CHAPPELL: I wanted to raise the question about public education and whether or not we have an accountability to the public for education about the kind of self-care or wellness that we are --

DR. GORDON: I would say most of that will come under the issue of public information and wellness. The issue that is here, though, that is relevant to what you are saying is we have a responsibility to make sure health professionals have a certain kind of education.

This is true for continuing education, as well as for undergraduate and graduate, so I want to raise something that wasn't addressed explicitly by the groups, which is this question that Tom is sort of raising somewhat indirectly.

What responsibility do we feel professional

associations or professional groups should have for providing ongoing education about CAM? I know it is a big topic, but if there are any sort of preliminary ideas, it will be useful to hear them now.

Just the way professional groups have a responsibility for providing ongoing information about what is within the purview of that profession, obviously within the purview.

Joe, go ahead.

DR. FINS: Logically, if you say that practitioners have a responsibility to protect the public health, and they know about what their patients are doing, they have an obligation if they are outside the undergraduate and graduate arena, and they are now near postgraduate, they have to engage, they have a responsibility for self-study to remain current.

If the demographics have changed and CAM is out there, they need to know about it. Who do they generally look to? They look to their specialty societies and training programs and the brochures, and all those kinds of things.

So, as a corollary, yes, the specialty

societies probably have a kind of obligation to their membership to provide them with educational materials that, in the context of their scope of practice, keeps them current, because it would be very hard, I think, for practitioner who wanted to simply fulfill the mandate in what we had established for the undergraduate medical education to do that independently without additional assistance from their specialty organization.

DR. GORDON: Linnea, were you going to say something?

MS. LARSON: Yes, I would actually like to comment on that and just reinforce what Donald's group came up with. It is enhancing the collaboration between different professional groups, and then to put that also in terms of this is how we are going to enhance our public information, et cetera, but to put that as a carrot, it is the AMA works with the Dental Association or the Oriental Medicine or this.

DR. GORDON: Wayne, did you want to say something?

DR. JONAS: I just want to suggest that we also, if we are going to go down the line of asking for

the accrediting bodies for licensed practitioners to look at the issue of use in integrated care, that we also ask the licensing bodies for complementary medicine practitioner groups to look at whether they have criteria for continuing education in their specialty and whether their continuing education criteria are evidence based and consider guidelines for making that stronger in those groups.

DR. GORDON: Thoughts about that? Joe.

DR. FINS: Not on that exact point.

DR. GORDON: Okay. Let's talk about that point. Joe, you are nodding your head.

DR. PIZZORNO: It seems like it should be balanced in both ways. It occurred to me as you were talking, Wayne, that the standard that is used for continuing education in natural medicine is standards of care, and that is the same standard that is used in conventional medicine.

I notice that that is the standard that is used to exclude from conventional medicine CME, teaching about alternative medicine CME, teaching about alternative medicine, because it is not the standard of care.

So, yes, you say we should do evidence based, you know, we have to be consistent with how we are doing this.

DR. GORDON: I am sorry, what was the last part?

DR. PIZZORNO: We have to be consistent with how we are doing this because it keeps coming down to don't do CAM, don't do CAM, don't do CAM, when you look at all these various criteria.

DR. GORDON: Yes, Joe.

DR. FINS: I think one of the things that would be a great thing for CME for all practitioners is the ability to understand there is a CAM literature and how do you evaluate CAM modalities and how much you think about incorporating them into your practice, as you would, say, decide whether or not to incorporate a new drug that came onto the market into your practice, what kind of prudential, you know, time frame would you want to adopt to say, well, we want to see how this thing looks after a period of time.

The other point which I was going to make before, which we haven't addressed is that, you know, the

finances of CME. This is a market, and if you don't address certain requirements, for example, you make this the wrong category of credit, it is not marketable.

If you don't put it on the licensure or the recertification or whatever kind of exam, it is not marketable. So, CME in isolation, without the accreditation piece, is not going to be viable because practitioners who have limited time and limited money are going to choose to go to the higher category and the ones that fulfill whatever criteria required in their specialty area.

DR. GORDON: So, really, you are pointing out that CME, there are at least two categories, the one that is required for licensure or for accreditation, and then other CME that would not be.

DR. FINS: I think the person who is going to go, you know, the sort of like going to the Andrew Weil course, the highly motivated, traditional physician who goes and wants to spend 200 hours learning about acupuncture, that person has gotten, you know, sort of interested in this, is going to be self-motivated, but the vast majority of practitioners are going to have to

have a reason to do this.

DR. GORDON: I think even for those people, the issue is crucial because if it is not accredited, then, you have to pay money to get accredited somewhere else. So, the issue across the board of getting credit for it is important.

DR. FINS: One last point about the economics is CME, I believe is tax deductible as one is professional expenditures and all, and I am wondering if CME that is not completely credible, you know, vis-a-vis the IRS, is tax deductible, so we might want to ask the IRS to come and visit, preferably after April.

[Laughter.]

DR. FINS: But I think basically, you know, what are the standards that make something tax deductible, because that is important to the personal finances of practitioners.

DR. GORDON: Other issues about CME or continuing education, not just medical education? We have a few more minutes. Joe, were you going to say something?

DR. PIZZORNO: I would like to address this to

Wayne. I have got my brain spinning on this. We are giving impetus or request to conventional medicine to teach CAM, and we are saying to them don't just limit yourself to standard of evidence that you don't necessarily apply to yourself.

Is there some feedback we should be giving to CAM organizations about the kind of continuing education they do, because, you know, one of the things we are wanting to do is to continue the evolution of CAM into CAM professions, as well as integration into professional medicine or conventional medicine.

So, I think if you go to a homeopathic conference and somebody is talking about a new remedy, well, what is the status by which a new remedy should be spoken about at a homeopathic conference. When I think about at a naturopathic conference I might go to, somebody is talking about using a new nutritional therapy, that is totally novel.

Well, what is the standard of evidence to be expected, that it is not something just totally outlandish?

DR. GORDON: Do you want to respond?

DR. JONAS: I think we should try to make more and more continuing education more and more evidence based across the board. I mean that doesn't mean it is the only criteria by which you approve or have to CME, but there should be elements of presenting the scientific evidence for anything you talk about even if it is -- guess what -- there is no data based on this, but it is my opinion. That is the level of evidence or that is what currently exists, but there should be an attempt at least to bring in the highest level of evidence that exists and teach that, and frequently what happens again in a lot of areas of CME is that someone gets up there and they are paid by a drug company or they just happen to be an expert in a particular area, and they say this is what goes, and that happens in complementary medicine, it happens in conventional medicine, and there is a big trend now, there is a big push now in conventional medicine to try to crack down on that by looking at conflicts of interest, for example, are you paid by the drug company and you have to disclose that, for example.

There is a big push for presenting better and more data from national bodies for meta-analyses, from a

variety of sources when that exists or at least some declaration of what the claim is based on.

You see that now compared to 10 years ago in conventional medicine, there is a lot more evidence-based presentations made than there were 10 years ago, and I think we should try to encourage that trend and suggest that all of these groups look at developing standards for evidence-based CME in their particular professions.

DR. WARREN: But does that totally eliminate the need for outlandish programs? Outlandish programs makes you look further. They give you little pearls that make you look on the other side.

DR. JONAS: It doesn't say you don't present opinion. It just says that you say this is based on my opinion. You say this is the level of evidence that exists.

DR. GORDON: So, what you are talking about is making explicit the criteria that you are using for a presentation.

DR. JONAS: Or the type of evidence on which it is based.

DR. GORDON: The type of evidence.

Linnea, Effie, did you have your hand up, as well? Linnea.

MS. LARSON: I just wanted to answer Joe. You asked about, you know, for the, quote, "non-allopathic," that was Group 4, and we said yes, you know, we want you to have exposure and training and continuing education.

Now, we are not specifically setting the standards, and then that gets into how are we going to and what information, what bodies will regulate or set the standards, but that was Group 4. Yes, this is an expectation.

DR. GORDON: Effie.

DR. CHOW: Back on evidence based, yes, the major conferences are asking for people to sign papers that talk about lack of conflict and evidence-based situations, but there again I would like to ask for a definition, a written definition of evidence based, because I questioned the medical board or the group of medical people. They kept saying evidence based, and they said, well, from just -- what do you call it -- episodal or anecdotal, anecdotal is if you got 100 anecdotal, or now Wayne is saying, well, just based on my

own evidence.

I think we need to clarify that because I think most people, when you talk about evidence based, it means really good scientific evidence, and I think we should clarify that.

DR. GORDON: Joe, and then Linnea and Tieraona.

DR. FINS: Two points. I think there was just an article in the New England Journal of Medicine in defense of the case report, so there is all kinds of evidence.

The second point is on the conflict of interest, and I just want to say something that I think everybody will endorse, but just make it explicit, that whatever rules for transparency and disclosure that exist in the conventional CME world, we would recommend strongly for anything in CAM CME.

It is very, very important especially the potential for all kinds of sponsorship issues that might distort, because I think if we are trying to establish the integrity and the credibility of these educational programs, they have an uphill battle as it is, but to have the possibility that there is a financial conflict

of interest further distorting what is being said is particularly problematic.

DR. GORDON: Linnea, Tieraona, Tom, and George.

MS. LARSON: This is real quick. The only thing I have to say is that David Sobel has an excellent description of what constitutes evidence, so I would just submit --

DR. GORDON: Do you want to make that available?

MS. LARSON: Yes, I can make that available. It is very, very short, and it is elegant.

DR. GORDON: Okay. Great. Tieraona.

DR. LOW DOG: I think mine just sort of follows on that. The USP, when we were trying to come up with how we were going to sort of do our levels of evidence on botanicals, everybody wanted to just use double-blinded RCTs or, you know, did the control trials count in that.

We actually added a category for historical and traditional evidence because when you are talking about evidence or proof, that is a type of evidence. In this field, I think it is important not to neglect that.

It is important to have the level of evidence,

but you can't talk about evidence as if history has no bearing, so I think that it is always important just to talk about what level of evidence we are talking about, is it historical or double-blinded or controlled or not controlled.

DR. GORDON: Tom.

MR. CHAPPELL: I wanted to just check with Joe on these questions of sponsorship. I want to say that the world of continuing education, particularly credits, is one in which professionals are asked to come to a location to be apprised of new developments, or not new developments, it's just basic information, and the cost of attending these things could be 20 bucks or might be 30 bucks, but believe me, that does not pay for the cost of putting that program on. I can also tell you that the universities aren't putting the money out to put those programs on, so the pockets, the deep pockets are the manufacturers, and that is the reality.

Now, I am all for disclosure, but you can't take the source of funds away from continuing education, and I just want to be sure you are not expecting that.

DR. FINS: I am not, but there is a notion that

the editorial -- I think this is an important issue because drug companies might give money to a university to establish an educational program, but they don't control the editorial content of the course work.

The problem here is that the relationship is going to be much more linear, and it is going to have the perception of a conflict that may not exist in other situations. I mean I think all of us who have gone to CME programs that are sponsored by a drug company are a little more skeptical when we hear claims for the drug than if we go to something from our professional society where we hear about the disease and the range of treatments.

So, I think there are different categories of CME. I agree that certain educational programs are not going to be sustainable without industry support in the private sector, but I think we should urge that sector and those kinds of CME activities to be very cognizant of, you know, the short term gain of sponsoring the program may have the unintended consequence long term of compromising the activity.

So, I don't disagree with you at all, but I

think it is something that they have to be aware of because I think it is going to be perceived problematically.

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

MR. CHAPPELL: Joe, does your professional association provide continuing education programs?

DR. FINS: Yes, but I pay for it.

MR. CHAPPELL: And how much are you paying, 20 bucks?

DR. FINS: Oh, no. I mean like, for example, hundreds of dollars. I mean the American College of Physicians has an 8- or $900, you know, payment.

MR. CHAPPELL: It is a fee-based approach.

DR. FINS: Right.

DR. GORDON: Let me just say one thing to clarify a little further. All these organizations are also supported directly or indirectly by pharmaceutical houses, as well. So, I don't think there is anyone -- it is very hard to be exempt.

MR. CHAPPELL: All pockets lead back to the drug companies. That is all I want to say. I include myself in that. I mean Tom's of Maine is the money

behind the University of Illinois at Chicago's continuing education for pharmacists, and they control the content, they have the professors and so forth, but it is our money.

DR. GORDON: Joe, and then Charlotte, and then I think we need to close this and move on.

DR. PIZZORNO: Actually, this conversation I think has been excellent because it has helped me think about what has been -- I have been following really hard about the ACCME, about the standards they were using, you know, it has to be evidence based or has to be taught in conventional medical schools.

I hear the word "evidence based," and I think, well, who says it is evidence based, well, people who are anti-alternative medicine.

So, I wonder if we could ask them to change their language to something like -- by the way, recommend to all the CAM educational organizations doing CME also -- that the level of evidence supporting the education be clearly defined, and that they define levels of evidence. I mean there is four levels of evidence ranging from this is well documented, we are real sure of it, to it is

anecdotal, should be on your radar screen.

DR. GORDON: I think that is what we are moving toward, Joe, that is what I am hearing a consensus for around the table.

DR. JONAS: I just want to make one small suggestion is that we use the word "types" of evidence. I think transparency is a key work, and I think types of evidence is a key word.

DR. GORDON: Charlotte.

SISTER KERR: I just wanted to, first, to affirm what Joe said ethically, but I also have a feeling we need to have a little reflection on this. You said let's be sure we are following the same standards, and I am not so sure those standards are the quality that we want to -- I am not so edified by those standards of the first-class trip to California by the drug company to learn about QRS.

DR. FINS: But that has really decreased.

SISTER KERR: It has decreased, but it is still there.

DR. FINS: I mean it has changed dramatically, and I think that it is a lot better than it was, but let

me modify it that the standards at least as good as, and maybe we can move the standard.

SISTER KERR: I think that is just what I wanted to say. Let's just give it a little thought again.

DR. GORDON: I think that is a very good idea, Charlotte, to give some thought to the kinds of standards that we feel should be in place regardless, and we can look at other organizations and other professions, but I think we are in a position to make our own statement.

We are going to move on now to the third area, which is licensure and credentialing. Joe.

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DR. FINS: Well, in the spirit of full disclosure, we didn't get that far. We got bogged down with this other stuff.

[Laughter.]

DR. GORDON: You got energized by all the other stuff.

DR. FINS: Right, so we really didn't have a lot to say. The one thing that I would say personally --

and this is not for the group because we didn't have a chance to vet it with everybody else -- was, you know, we heard a lot about CAM providers having problems with state medical boards, and I think that the state medical boards have a prerogative to protect the public health, but I think there should be some kind of immunity granted for practitioners who are participating in federally-sanctioned, N-CAM-related trials.

So, I think if somebody comes forward and participates and passes peer review, and is trying to collaborate with the federal government in a Best Case Series or something through N-CAM or clinical trial, the participation in the federal activity should somehow immunize that person in educational related activities.

DR. GORDON: Noted. I think also some of that we may come back to when we come to research, because it is stated as a research issue the way you said it, but it may also be an educational issue in a slightly different form.

Group No. 2. Don.

DR. WARREN: Charlotte, Julie, David, and I, and Corinne came up with really and truly licensure is

not our purview, we should not be looking at licensure, because it is the responsibility of the individual states to do that, and we just backed out of it right there.

DR. GORDON: Okay. We will come back to that. We may have some questions for you, but we will come back to that.

Group No. 3.

DR. LOW DOG: Again, our group was looking at physicians that practice integrative medicine or health care providers, and so part of what we wanted to define was also what actually did we think people should know when they come out of school, starting there.

So, we believe that the nationally recognized accrediting organizations should develop and incorporate standard and review criteria for evidence-based core competencies and CAM, and those would include, so that every practitioner, nurse practitioner, pharmacist, et cetera, would come out with a knowledge of CAM practices, skills in assessing complementary and alternative health practices in culturally sensitive ways, so that we are looking at diverse populations, skills in critical appraisal of safety and efficacy of CAM practices, so how

do you look at the material, ability to communicate with and guide patients about complementary and alternative medicine use, and again sort of guiding people through the maze and the myriad of things.

Ability to refer, follow, and collaborate with complementary and alternative health care practitioners in developing an integrative patient care as appropriate. We realize licensed practical nurses, R.N.'s, they may not be referring and doing those things, but we wanted to include that their referral and collaboration should be part of what we expect people to leave medical school and residency with, those core abilities, and that those should be part of what their tested on in that, and as part of their education, that is what we expect from them.

Medical boards, we did address this as far as education and the concerns of nurse practitioners, physicians, et cetera, who are practicing. We felt that medical boards should include members and/or consultants who are trained or experienced about complementary and alternative health care practices on their boards, so that if somebody is brought up on some sort of charge,

there is actually people that are familiar with what they are doing and that could have an opinion.

Physicians or other health care providers who use complementary and alternative health care practices should be held to the same standard as they would normally be held. So, the only thing we are asking there is that there not be a double standard, that we are not persecuted by our boards.

We also recommended that there is work with oversight bodies, such as the pharmacy boards, state nursing boards, the SFMP, FDA, et cetera, with the development of guidelines for the delivery of complementary and alternative health care practitioners, practices by licensed professionals, so that would be groups that oversee medical doctors, as well as nurses, pharmacists, licensed midwives, et cetera.

As far as those who -- the question is often raised especially by those who practice alternative therapies or acupuncture, et cetera, do physicians know enough, you know, that is always the question, how much training.

Again, we didn't adequately answer that. We

just felt that all health care professionals who practice these other modalities should have adequate training for doing what they are doing, and, of course, that will vary by modality. If you are going to add glucosamine to your prescriptive regimen, you don't have to go out and take 200 hours to be able to do that if you have reviewed the peer literature, however, if you are going to be administering acupuncture, there should be sufficient training, so it was really modality by modality.

DR. GORDON: Great. Group No. 4.

MS. LARSON: Again, I am going to read the question, so everybody can hear it, and, Buford and Tom, I am going to rely on you guys to give the information. The information also is written on these white pieces of paper, if you can read it.

Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, and to whom should they apply, and how should they be implemented?

Thomas.

MR. CHAPPELL: It seems like a very long while

ago that we met to discuss this.

[Laughter.]

MR. CHAPPELL: We are relegating the certification to the boards of the professional groups and entities, and the purpose of the certification -- and we do want certification -- is to provide consumer confidence in that modality or therapy.

We mentioned Minnesota's new laws where more disclosure about the role and skills of the practitioner was also very helpful to the consumer.

Now, we talked specifically about certification in this. We didn't talk about national standards. We didn't see them as synonymous. We just focused on certification. I think it is a little harder for a group such as ours to have national standards, but that it is the certification process where that standard is affirmed by the professional organization.

So, as a practical matter, we focused on certification in this.

MS. LARSON: No. 2. Should there be condition-specific or modality-specific practice guidelines, and why or why not? If so, how and by whom should these

guidelines be developed, to whom should they apply, and how should they be implemented?

MR. ROLIN: We said that we didn't know on this one, because in the absence of health services research, you can't just determine that.

Also, we added that we felt like through long-term research, practitioners would focus, would be placed on the consumer's best interest in this area.

MS. LARSON: But I hasten to add that it was significantly the statement of health services research, health services.

DR. GORDON: Significantly? Can you just elaborate?

MS. LARSON: It is health services research. That is an umbrella defined by types of research and types of evidence, so it does not specify, but I think it's important that we have an umbrella there.

DR. GORDON: An umbrella for what?

MS. LARSON: For directing, that we actually do want to have health services research to be able to answer the condition-specific or modality.

DR. GORDON: Other questions?

MS. LARSON: We have got one more. In terms of quality of CAM practices and products, very quickly. A. How and by whom should quality be defined? B. How and by whom should quality be measured? C. What should consumers be told about cost safety, effectiveness, and time for effectiveness to be evident of CAM practices and products?

This is a dissertation, and we did not write it. We referred it to higher authorities. Consider ARQ recommendations.

DR. GORDON: I am sorry?

MR. CHAPPELL: AHRQ.

MS. LARSON: Yes, but I don't remember what the tab is. Dr. Kamerow's response in your binder spells it out.

DR. LOW DOG: Can you give us the gist?

MS. LARSON: No, I can't at this time.

DR. GORDON: I am not sure what you are saying, though. You are saying consider --

MS. LARSON: Oh, that the commission should consider directing the attention to the report given to us on these questions by Dr. Kamerow.

DR. GORDON: I see.

MS. LARSON: Discussion Group 4, Tab 1, one page.

DR. GORDON: So, you are saying they make a proposal and we should take a look at that proposal.

MS. LARSON: Yes.

DR. GORDON: Are you in accord with the proposal?

MS. LARSON: I think it is logically argued.

MR. CHAPPELL: We are not endorsing it. We think it is a good piece. Is that right?

MS. LARSON: Yes.

MR. ROLIN: It's a place to begin.

DR. GORDON: So, we will begin with that, and maybe we will distill something from that.

MS. LARSON: This is a very difficult question to answer, and there are people who have looked at it in depth and who have established quality measures, et cetera, but I don't think that we -- I am not prepared to do it, but I can point to, from having solicited the information and having kind of valued the research elements that this particular entity has done.

DR. GORDON: Discussion Group 4, Tab 3.

Linnea, other questions?

MS. LARSON: We have two more. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral from the conventional provider or without a referral as when a consumer self-refers?

We would refer the rest of the commission members to Dr. Rossman's articulate explanation, which is Tab 1, page 4.

DR. GORDON: Group 4, Tab 1, page 4.

MS. LARSON: What that is, it comes under a mental health kind of model which respects the patient client's privacy and puts at some level the burden on the relationship between the patient client and the provider.

DR. GORDON: You have one more question?

MS. LARSON: One last one. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products?

DR. GORDON: And?

MS. LARSON: The answer is yes, and we do recommend delegating to this entity this -- no, no, no -- outside the entity, but saying, okay, this office, that we would like the coordinating office to delegate the authority to create and help develop a kind of consumer safety board.

DR. GORDON: Okay. Thank you.

Let's have some discussion of any or all of these issues that are raised regarding credentialing and licensure. Joe.

DR. FINS: Just this notion of evidence which is related to credentialing and licensure and assessment of practice, in the House of Lords report, in Chapter 7, there is an excellent discussion about the various kinds of analytical frameworks and the kind of information that they provide that might be helpful as we move forward.

Related to what Group 4 was just talking about, I think it was in Part 3 or something you were talking about referral and information. I am very concerned about this one issue.

I am very concerned about people who are terminally ill, who have not received adequate end-of-

life care in the mainstream, were given a false choice about continued, say, chemotherapy which was not efficacious, not receiving adequate pain and symptom management, were never offered the hospice option.

They go to their CAM provider, and it is sort of a desperate situation, and I don't think the CAM provider should recapitulate the lack of referral that occurred in the traditional setting, so I really think it is very, very important that practitioners of all stripes recognize what might be a futile situation.

I appreciate their ethical obligation to provide adequate palliative care and pain and symptom management, make a hospice referral. I think that is critically important because it is just as egregious an error in the CAM realm as it would be in the traditional realm, and I think we have to recognize limits.

I remember asking Dr. Atkins a question at one of the last meetings, have you ever had a treatment failure, and he said no, which I thought was the height of hubris and problematic, but I think that we don't want to perpetuate that kind of lack of referral.

DR. GORDON: So, that is continuing education.

DR. FINS: No, I think it is a deviation from accepted practice to not refer somebody.

DR. GORDON: I understand, but how does this fit into credentialing and licensure?

DR. FINS: Because the boards that look at practices would say this was not professional, this is not professional conduct. It is a deviation from what the standard of practice should be.

DR. GORDON: So, is there a recommendation that you are making?

DR. FINS: That credentialing bodies and oversight bodies for practitioners, whether they are CAM practitioners or non-CAM practitioners, are sensitive and informed about palliative care and the importance of referring people to appropriate palliative care.

I am very concerned that people who embrace CAM at the end of their lives are a desperate population, and they are perhaps more vulnerable to exploitation than people in other parts of the life cycle.

DR. GORDON: Okay. Tom, and then Tieraona, Joe, George, and Effie.

MR. CHAPPELL: I wanted to address one of the

questions for our group, and that is the one, No. 3, in terms of quality of CAM practices and products. The focus here on this is on quality.

I think this misses the needed intent. I think the question needs to be addressed toward safety and efficacy or at least if we are going to talk about herbal remedies or supplements, it is more valuable from a consumer perspective to talk about safety and effectiveness because safety is covered in the question of quality.

DR. GORDON: Tom, the questions are more in the area of services, I think, and more in the area of research. I would like to focus -- we just have a little bit of time on credentialing and licensure issues for these next minutes. We will come back to that in the final meeting for sure and maybe in public information, as well.

MR. CHAPPELL: Good.

DR. GORDON: Next is Tieraona.

DR. LOW DOG: My question was when we were going through and you had recommended certification for all of these groups, could you expand on that a little

bit? I am not quite sure what you mean by that.

MS. LARSON: What we looked at was the "evidence" that we received from the groups. Some of these groups do not have a license, but they do have a certifying body different than the organization that may eventually be able to lead to licensure.

So, we sidestepped or did not deal with the issue of national standards. It is we leave to the groups, such as the yoga group, that says we have standards, then, we certify that our teachers or our practitioners have done X, Y, and Z. That is all we have done.

DR. LOW DOG: Can I follow up?

DR. GORDON: Sure.

DR. LOW DOG: I guess it is two parts. One is that I think there is thousands of lay healers, however you want to define them, herbalists, naturopaths who have not gone through the training, that are out there practicing.

Are you recommending certification for all of these people? I guess that is my question. I think it is an important question.

MS. LARSON: I don't think that there was a notion that there needs to be or should be certification. We simply answered the question, you know, it is national standards or certification. Yes, if this organization wants to create certifications with certain categories of expertise, yes, do it.

DR. GORDON: So, it is voluntary is what you are saying.

DR. LOW DOG: No recommendations for --

DR. GORDON: No, I don't hear a recommendation. For certification across the board, I am not hearing that.

George, go ahead.

MR. DeVRIES: I want to open an item up for discussion related to licensure, and it really relates to the issue of several specific provider groups. I am thinking in the area of chiropractic, there is very consistent licensure state by state across the country, so that already exists.

But if we look at several other provider groups, for example, massage therapy, we heard yesterday from AMTA that there is very inconsistent licensure

across the country. We know that is also true to an extent with acupuncture, and then we know with naturopathy, only licensed in about 11 states.

We recognize that the regulation of health care licenses is a state prerogative, a state authority, however, believe that this commission can help these professions to take a strong step forward in perhaps recommending not the exact, shall we say, licensure statute that a state would enact, but really some guideposts, some minimums related to education and other issues that would support those professions in those states who are struggling to be viewed credibly by their local state legislature and to gain the foothold, the credibility to be able to enact legislation that would help them to become a licensed provider group in that state.

So, what I want to open for discussion, and I am asking this commission to do, is make recommendations related to the areas of acupuncture, massage, naturopathy, that can provide guidelines, minimum guidelines that states can utilize as part of creating statutes for licensure.

DR. GORDON: That is fine. We can talk about that right now. I want to just make one addendum to that. We can either formulate guidelines or simply make a recommendation that there should be guidelines that another body would later on decide on, because we may or may not consider it within our purview or within our possibility right now of doing that.

So, let's have discussion on George's suggestion, and then we will come back to Joe and Effie.

DR. PIZZORNO: I would like to hear from Linnea because I saw her nodding.

MS. LARSON: I guess I am somewhat confused because this "subgroup" is that we have throughout it said yes, there should be standards, there should be standards of education, there should be undergraduate, postgraduate, and continuing education.

We are not placing restrictions in terms of licensure because that is not under our purview. We recognize that there are states, but we are pointing. We also looked fairly closely at the excellent information that was given by the naturopathic physicians in terms of detailed analysis of what could be possible, but I don't

feel, and our group did not feel or think, that it was our charge to spell that out.

It is our charge to say yes, there ought to be standards and point a direction to it.

DR. GORDON: George, do you want to respond to that or anybody else want to respond?

MR. DeVRIES: Let Joe.

DR. PIZZORNO: Well, I am happy to hear that. What was presented didn't sound to me like what you just said, and I think it is critically important that this commission come out with a position that says that when there are professions out there, they should have clear educational standards, clear standards of practice, and that licensing should be consistent with those educational standards.

I think this commission should say it real clear. Now, we don't have to specify whether it should be for profession by profession, but we need to clearly specify that there should be consistent education and licensing consistent with that education.

MS. LARSON: Maybe that was not spelled out word by word, that was the intent, and then we should be

very clear about having those specific words in the recommendation.

DR. GORDON: George, do you want to respond?

MR. DeVRIES: Yes, and I appreciate Linnea's follow up. Just clearly as we discussed earlier, we talked about the concept of loan and the forgiveness of the loan repayment for providers who are licensed. As we talked about that as a foundational element for that particular way of funding education, I want to acknowledge that the concept of licensure for provider groups really is fundamental in their ability, in some cases, like with naturopathy, to practice in certain states and to be able to operate with authority in those states and to quality for reimbursement, which we haven't dealt with yet as a commission, but that is typically a line that is drawn by many health plans, which is are they licensed or are they not, and if they are licensed, there is an ability to work with those providers, to credential them and include them in reimbursement systems.

MS. LARSON: I would like to respond to that because I think that this is a process in which we are

articulating a variety of positions and coming to a kind of common ground.

Now, you moved into what will be our next discussion, which is reimbursement, but we are talking about standards of education, so that will inevitably lead to the logical extension of how do then we reimburse.

DR. GORDON: I am still not sure. Are you recommending that there should be uniform standards of licensure for professions or not? No. So, you differ from what George was saying or not? I am trying to clarify what the difference is between what George and I think Joe seemed to be saying and what your subcommittee said.

MR. CHAPPELL: As Linnea has said, we are very clear that we expect there to be standards, educational standards at all levels of education. We believe that those standards need to be articulated by the professional groups.

From there we moved into certification. We believe that certification is a way to enhance consumer confidence, that those standards are in place, but we

didn't touch licensure.

MS. LARSON: We were not given the question.

DR. GORDON: Okay. Now, the question is now coming up.

MS. LARSON: Yes.

DR. GORDON: So, I think we need to spend a few minutes addressing this very important question that George and Joe have both raised about licensure.

MR. CHAPPELL: I would like to comment on it then. I don't know how we, as a national organization, if that is what we are, or a policy recommending organization, would be able to provide any quality assurance for the licensing process because it is individualized by states.

I think third party reimbursers might be able to do that, but I don't know how the educational content can be driven by that.

DR. GORDON: What we can do, and I don't want to take away from you, and I know, Tieraona, you need to speak, but what we can do or not do is make recommendations that there should be uniform standards of licensure and that professions that are licensed in some

states --

MR. CHAPPELL: We put our emphasis on the word "certification," not licensure.

DR. GORDON: I understand. Now, we are talking about licensure.

MR. CHAPPELL: And I personally don't -- I don't have an investment in licensure.

DR. GORDON: Okay. The discussion now is about licensure, and it is open to anyone talking about it. Tieraona, did you want to address it because you have had your hand up before?

DR. LOW DOG: I don't think so.

DR. GORDON: Okay. Joe.

DR. FINS: I think there should be licensure and there should be standards, and that is where we have uniformity, that there is such a thing, but it does not need to be the same from state to state to state. That, I think is where the two sides of the table link up.

MR. CHAPPELL: Would you repeat that, please?

DR. FINS: That we believe in standards, we believe in licensure or credentialing, but every state has its own prerogative at setting the standards. I mean

that is federalism, and it is the prerogative of the state to set standards. We think the state should set standards, but it is up for them to determine what the standard is.

DR. GORDON: George, go ahead.

MR. DeVRIES: First of all, at least as I have seen it with both massage therapy and acupuncture, there is a distinctive difference between certification and licensure among states, and that while certification is good, there is a gulf and it is distinctively better when acupuncturists are able to be licensed or massage therapists are able to be licensed typically in a state.

Second of all, the question was asked why would this commission recommend licensure, that states proceed with licensure of provider groups, or why would we come up even with some basic guidelines as minimums for the licensure.

The reason I suggest that we consider it is that for some of these provider groups as they go and lobby their state legislatures to become licensed, to enact statutes that allow them to become licensed, it is a very difficult job for them, it is very expensive,

there is opposition. It is a grass-roots effort. They don't have much money. It is a struggle, it takes years.

There is multiple cases of them failing to achieve certain things out there in terms of obtaining passage of laws to help them get licensed, and if this commission took a position recommending that the state legislatures license these provider groups, and to use reasonable criteria or guidelines in doing it, it would support those providers in the field as they are trying to work with their legislators to get licensed, to get statutes passed to be licensed.

It would give them a tool to use in the field. It is just my sense from experience is that they need these tools out there as they are working with their legislatures to get some kind of statute passed.

DR. GORDON: Effie, you had your hand up before. Did you want to say something about this issue?

DR. CHOW: I think George already said that.

DR. GORDON: Okay. Tom, and then Linnea again.

DR. CHOW: I have another issue.

DR. GORDON: I understand.

MR. CHAPPELL: I hear the advice, George, and I

don't want to argue against licensure. I want to say that what we were attempting to accomplish by focusing on credentialing was so that a naturopath in Maine would essentially practice the same standards in Oregon. If I were a consumer, I could expect an M.D. to practice the same competencies, and so forth.

So, we saw the professional organization being the maker of those standards, and we want, as an organization, to affirm the need for that from the consumer's point of view.

Now, you are bringing up licensing as a provider-driven need, but as a consumer, I am not sure that that --

MR. DeVRIES: Well, just, Tom, to agree with, agree with you except that naturopathy is only licensed in 11 states, and this is about helping naturopathy to be licensed, not in 11, but in 22, 33, 45 states.

MR. CHAPPELL: I hear the recommendation.

DR. GORDON: So, your point is that without licensure, consumers don't have access to naturopathic physicians in those states.

MR. DeVRIES: That's right.

DR. GORDON: Veronica, and then Joe.

DR. GUTIERREZ: I think the problem with licensure goes back to what I have been saying from the first meeting I attended, and that is we need a definition of scope of practice, intent, and purpose. There wouldn't be as many turf wars, there wouldn't be as much difficulty being licensed, certified, or at whatever level, if every group defined what their goal and mission was.

DR. GORDON: So, that would be part of the process of licensure, as well as part of the process of certification. Okay. Joe.

DR. PIZZORNO: Tom, I think it is important to emphasize the public safety aspect of this from the consumer perspective, because, as you say, in Maine, a consumer can go to a naturopathic doctor and they are well trained, and can expect a positive outcome. Unfortunately, they can go two states over and go to somebody who calls himself an naturopath, does not have the training, and they are expecting the same kind of experience they got in Maine where there was licensing.

So, it is an incredible consumer protection

issue that when a title is used, that has licensure status, that that be used consistently.

DR. GORDON: We have 10 minutes left for this discussion, for all the discussion about licensure and credentialing. I want to take sort of a pulse of where we are with this licensure issue right now.

Is this something we want to take up at greater length later, is it something there is a consensus about at this point that we are looking towards standards, uniform standards of licensing for CAM professions -- I will ask that as a question -- or we just want to put it off and talk more about it later? Joe.

DR. JONAS: I think we want uniform standards like, you know, credentials, like board certification, but each state can say what the standard is for licensure and what the elements are.

DR. GORDON: But there are two questions. There is the elements of licensure and the fact of licensure. Do you see what I am saying? Let's say for naturopathic physicians, if there is no licensure at all, then, it doesn't make any difference what the standards are.

Do we want to come down -- and I have a feeling we may not be ready for it yet, I just have the sense -- but the question that is in the air is do we want to come down and suggest that those professions who may be licensed in some states, to support their efforts to gain licensure with appropriate standards in other states.

DR. FINS: The paradox is that if you look at conventional medicine, the certification is a higher standard than licensure.

DR. GORDON: Right.

DR. FINS: And here, licensure, if you are not in the right state, is a higher certification than something that should be higher, so it's an illogical situation.

DR. GORDON: Linnea.

MS. LARSON: Just one last thing. Simply, we are focusing on naturopathic physicians. This had to do with many more groups, and we looked at the clarity, the logic, the documentation that naturopathic physicians gave and said let's look at this, but we also have other groups that we are making recommendations concerning.

Certification often has little bit higher

standards than licensure. That is why I said let's look at this issue, but we also know that licensure for third party is tied to reimbursement. So, it is answering the question certifying for all of these organizations, national standards.

DR. GORDON: The other thing that we need to say, though, Linnea, that is a separate issue, is licensing is also tied to ability to practice. I have a feeling we need to have some more discussion about this.

Other issues? It is clearly in the air we need to find a way to come back to this, because it is a crucial issue. Are there other issues related to licensure or credentialing?

The one that I would like to sort of reemphasize is the one that relates particularly at this point to physicians, although it could relate to any other licensed professionals in the states, to creating a level playing field.

I think this was mentioned in a couple of the groups' recommendations for those people who are using CAM approaches, that they have the same kinds of criteria, the same kinds of respect for them and the same

kinds of expertise on the licensing boards as for the conventional physicians or conventional practitioners.

That is, that if there is a nurse of a physician or an acupuncturist who is licensed, that the same kinds of standards be applied, that simply because they are using CAM approaches, they not be discriminated against in any way, and that CAM practitioners or experts be on the boards.

I am sort of extrapolating from some of the recommendations.

DR. CHOW: On that part, it is the reverse. The protection of the practitioners or the medical practitioner, nurse, medical doctors, I believe that is very essential.

On the other hand, I think because we are nurses -- I am speaking about myself as a nurse -- and doctors or pharmacists, because they have the training in medicine does not make them experts in the other field. I think that needs to be placed as a very strong issue, and that the same standards of training and licensing and certification should apply to the medical profession.

In other words, no little weekend courses, no

diminished courses.

[A/V failure.]

DR. CHOW: So, I am saying that because we are nurses or M.D.'s, that studying another practice doesn't make us automatically more knowledgeable about that practice particularly when there are varying theories and principles, so that the certification and licensing of those professionals need to be as stringent as the CAM practitioners.

DR. GORDON: So, you are saying that somebody who is licensed --

DR. CHOW: Who is a nurse or an M.D. or pharmacist.

DR. GORDON: And if they practice CAM?

DR. CHOW: And they want to become a CAM practitioner, they should undergo the same stringent training.

DR. GORDON: I think this will be an issue of some debate. For example, the example that we used to bring out this point was the example of acupuncture in particular, where Dr. Helms said, well, we have the international standard which says it is okay to practice

acupuncture with this amount of training if you are a physician or even if you are not a physician, there is an international standard, and then Dr. Lao saying, well, a standard-setting body of a group of acupuncturists in the United States says there is another standard.

So, what we have is conflicting standards of different groups, and if you look across the board at the different professions, we are going to find many, many different standards, not just for acupuncture, but for many, many different practices.

It is going to be a major issue, and I think that it is a hard one, one that was not discussed in detail up until the present time, and since we have about three minutes left --

DR. CHOW: I would like to put that on the agenda to discuss that.

DR. GORDON: Let's see what we can do about addressing that. One of the things I want to say, so that we can all take a deep breath, is that part of what we are hoping to do in October is come back to some of the issues that we have not resolved now, and I think it is much better for us to wait with issues where there is

a lot of controversy or a lot of unanswered questions rather than try to hurry to a conclusion now, to give ourselves time and gather information and come back again in October and work on those issues. So, this can be one of those issues.

Joe.

DR. PIZZORNO: I think Effie has raised an important issue, and I would actually pursue it more from the standard of care rather than from the standard of education.

For example, if I used an antibiotic, which I am licensed to do in the State of Washington, and I don't use it very often, but if I did, the standard of care I would be held to would be that of a naturopathic physician using an antibiotic.

Now, if we have a medical doctor using an herbal medicine or an acupuncture or something of this nature, what is the standard of care that medical doctor is being held to?

I think that needs to be established because right now while it is in the purview of the license, there is not a standard of care to determine when the

public is being properly served, and I have substantial concern about that.

DR. GORDON: So, this is clearly an issue with many ramifications.

DR. CHOW: I think it goes back to Tom's point that everything we are talking about is really customer based, you know, driven, so the reason for our discussions is for more information on a positive level.

DR. GORDON: I think it is time for us to take a break. What we have done, just to recap a bit, is we have a number of issues on which there are some general agreement, and we have several issues, particularly the last two that were raised, about which there is a lot of discussion, a lot of unresolved issues related to them that we can come back to at a future time. So, this is a very good discussion. I want to thank everybody, the continuing education chairs and the whole group, for their participation. This has been great.

[Applause.]

DR. GORDON: We are going to take a 10-minute break and then we are going to come back for the public comment session. Incidently, thank you very much, those

of you who are participating in public comment, all of you. We have gone about 15 minute overtime, so thank you for your patience.

MS. CHANG: Let me just let you know who will be the first six up to bat, so you will get ready to come up in 10 minutes. Susan Silver, Margaret Huddleston, Robert Scholten, Rustum Roy, Diane Miller, Susan Bonfield Herschkowitz.

[Recess.]

Public Comment Session

DR. GORDON: The rest of the meeting today will be devoted to public comment. We are going to be calling up the panelists in groups of six. Each panelist will have three minutes. Just as we were with the other speakers, we will be somewhat draconian in making sure it is only three minutes.

After all the panelists have spoken, there will be an opportunity for Commissioners to ask questions after each panel of six has spoken.

I will call off the panelists to speak in the order in which they are written, in which they signed up.

First is Susan Silver.

MS. SILVER: Thanks, Jim.

I am Susan Silver. I am the program director of the Center for Integrative Medicine at George Washington University Medical Center right here in Washington. I am the principal investigator on a project that I am going to describe to you that allows us to prepare and implement a model training program for medical students in CAM.

The limitations of time are going to force me to give you the no-frills version, but I do want you to understand that we are specifically addressing the problem as follows, that medical students in our medical school and others are certainly well prepared in biomedicine and allopathic medicine, but they are almost entirely without information on CAM as it is practiced by Americans and as it is practiced around the world.

In order for those physicians to treat their patients comprehensively, particularly given the increasing use by the population of CAM, they need to be able to evaluate and advise their patients on what they are using. They need to know the questions to ask them, and in order to do that, they need to be familiar with

not the practice of CAM modalities per se, but with the principles of practice and the integration of practice with conventional medicine.

I am an investigator on a project that was funded just this past fall by the Department of Education, specifically, the Fund for the Improvement of Post-Secondary Education, FIPSE.

It is a three-plus year grant that will let us work with our first year class, that is, our first year medical students of this year throughout their medical school career.

Just briefly, what we are going to do is involve them in three distinct modules, as we call them, the first being experiential where they will become our patients and experience CAM through themselves.

The second is didactic where they will actually participate in group discussions, and so on.

The third is participatory where they will shadow out professional providers in our clinical practice at GW.

We hope by exposing them over that long period of time to CAM as it is practiced, their knowledge of CAM

will grow with their knowledge of allopathic medicine, and our greatest goal is to not only incorporate the program into our own medical school curriculum, but to make it replicable, so that it can be reproduced in other medical school settings and broaden the sphere that is impacted by teaching CAM.

DR. GORDON: Great. Thank you.

Next is Margaret Huddleston.

MS. HUDDLESTON: Thank you. I am Peggy Huddleston. I am a psychotherapist and author of this book Prepare for Surgery, Heal Faster, and a companion relaxation healing tape.

I have developed a five-step protocol that shows people how to use mind-body techniques to prepare for surgery and to become much less anxious. Actually, they become profoundly peaceful before surgery. They use 23 to 50 percent less pain medication after surgery and heal much faster.

I have also developed a two-day training program for health care professionals for which they receive 13 1/2 CEUs that I have taught to professionals across the country.

I am also the principal investigator of several research studies documenting the program at several Harvard teaching hospitals. I have just completed a randomized, controlled study. We picked patients having total knee-joint replacement because everyone said that is the most painful and the worst, so we picked that on purpose.

We found that patients using this protocol, which involved a book and a tape, which wholesales a cost for a hospital $15.00, or usually the patient pays for it, wound up saving the hospital about $3,000. The patients were much calmer the day before surgery compared to the controls, and they also left the hospital a day and a half sooner with the DRG, so it saved the hospital that money.

We are also just starting two other studies at Mass. General with patients having open heart surgery and abdominal hysterectomies. My program is currently used by hospitals, I guess it has already been used by more than 200,000 people around the country, self-guided, with patients using the book and the tape themselves.

It is also being used now at hospitals across

the country including NYU Medical Center in New York where I have trained 18 nurses there. Several Kaiser Permanente hospitals are using it, UCSF Cancer Resource Center, Saint Barnabas Medical Center, the largest chain of 14 hospitals in New Jersey, and others that I have listed here.

There is an article that I included for you, that was from the recent issue of OR Manager, that talks about Kaiser's results, the data they have collected, and how much the have found it increased patient satisfaction, and since Kaiser owns their own hospitals, to their delight, it was saving them about $1,000 per patient. When the length of stay was normally four days, it was coming down to three days.

I would urge the committee to provide more funding for this program. If I have 30 seconds left, I will tell you what it includes, but tell me when the bell rings.

MS. CHANG: You will know.

MS. HUDDLESTON: The program has patients use a relaxation tape. It is 20 minutes long, and they use it twice a day. The second step is they take their worries

and fears and turn those into positive healing imagery. The third is they create a support group. The fourth is they use healing statements that lessen the use of pain meds following surgery. If any of you want a copy of the book, just give me your card and we will mail you one.

Thank you.

DR. GORDON: Thank you. It says that you enclosed a copy of an abstract of the research study. I don't think we have that.

MS. HUDDLESTON: I decided not to, because I am about to submit it for publication. I am just afraid maybe it won't be kept confidential, so I reneged the last second.

DR. GORDON: Okay. Thank you.

Robert Scholten.

MR. SCHOLTEN: Dr. Gordon, Commissioners, thank you for this opportunity to speak. I am going to read my speech if you will forgive me.

The concern and dedication that I observe here is laudable and I thank you very much for doing what you are doing. I am a librarian by training and have been the information officer at the Center for Alternative

Medicine Research at Harvard Medical School for four years. I also coordinate our four CME courses that are given to over 1,000 people each year. These CME courses are cosponsored by Stanford and UCSF.

My remarks today concern access to information on complementary therapies by the students, conferees, researchers, and clinicians with whom I work on a daily basis. Their requests are easily summarized - what is the aggregate of evidence for use of these therapies, where is this evidence located, if only anecdotal information exists, is it recorded, and how can I get ahold of it, if the therapy is part of a historic tradition, is it documented authoritatively, and where.

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

currently in the public domain.

I therefore invite you, the commission, to consider the creation of a task force charged with the creation of an information strategic plan that is truly international and collaborative in nature.

This task force should be equipped with a federal mandate and concomitant resources that would allow it to open negotiations with the World Health Organization, ESCOP, Ministries of Health of other countries, and other worldwide stakeholders.

Its principal goal should be to ease access to existing data, coordinate the creation of new databases on a collaborative basis, and set standards for data including an exchange specifically in the field of CAM.

This task force should initiate an inventory and critical evaluation of the current state of information resources available to the English-speaking CAM researchers today. This should include all governmental, quasi-governmental, and commercial initiatives.

It should specifically seek to identify existing databases that remain largely inaccessible to

scientists for one reason or another.

Finally, they should survey scientists, clinicians, and information professionals in order to determine whether or not the current resources are considered adequate to their work, authoritative enough to allow proper prioritization of research projects, and clinical recommendations.

I would --

[Interruption.]

MR. SCHOLTEN: -- like to stop now.

[Laughter.]

DR. GORDON: Thank you.

Rustum Roy.

DR. ROY: Once I heard Tom Chappell's statement, which got all the clapping, I threw away my script, and I said, well, he said it all. My position is basically that you have been concerned about education of the practitioner.

At the end of your package for me, you will see a graphic like this from Arizona State University where I work, and you will see two cohort groups, the practitioners including all the CAM practitioners and the

citizen-patient. That is the last graphic.

My remarks are confined entirely to the citizen putative patient. I urge you to say, as everybody in this room, I don't need to tell any alternative practitioner, that half the equation is on the other side, it is the patient who is receiving whatever treatment is being offered that is the really key person, and the education of that citizenry. This is a consumer-driven movement. That is what Tom was saying, and it is not going to stop, it is going to go gang busters.

We want to get systematic, more or less reviewed and checked out through the formal educational systems. In college, we have got students at Penn State now. We are starting at Arizona State in the regular, not medical student, regular student and K through 12, that can get the information they need. It is going to be very generic, but it is going to be the kind of information which makes them much more informed, much broader.

Today, the less wealthy and less educated citizenry don't get this information. It is the wealthy that are getting the alternatives. We have got to get it

down. So, I urge you to focus on that group.

I am a hard scientist. I worked with Andy Weil for four years on preparing the things you are talking about and in the CME material, my lectures are in that, and I think that we really can drive the system by going even broader.

We have got 7 1/2 million students in college. We have about three or four times that in high school. We need to really access that cohort group.

How to do it? In 1982, Reagan had zeroed out the science education budget. Science education was zero. Today, it is $775 million a year. I propose if you recommend to a joint NSF/public health group to do funding for education of the citizens in the craft that you practice, they really will need to be educated. They are the people who are doing to do it.

I end with Hippocrates. Hippocrates said, "It is important to know the person who has the disease than the disease the person has." I am going to say it is more important to educate the person who is supposed to be a patient than the doctor. I am not going to say they shouldn't be educated, too, but let's educate the other

half. So, I am here to advocate that this commission recommend the education of the other half, and I know you are known for balance on that.

Thank you.

DR. GORDON: Thank you.

Diane Miller.

MS. MILLER: My name is Diane Miller. I echo the consumer approach that I will be speaking about today. I am an attorney. I am the Executive Director for the National Health Freedom Coalition, former defense counsel for many healers, and the draft and lobbyist for the Minnesota Model of Legislation.

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

There are thousands of unlicensed healers permeating throughout this whole culture, many in solo practice, without affiliation to national groups, with a broad array of backgrounds and talents, many of whom use a combination of skills to assist consumers. Affiliations with institutions or national organizations

is not desirable for many of these healers, and the consumers don't require it either.

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

There are thousands of these practitioners out there practicing, and they are usually practicing specific to their own personal interest in healing, having gotten their information from many resources and utilizing it to assist patients.

3. Very important from today's conversation, I would like to just say this, and I would like you to get more input on this. Educational credentials or degrees are not the same as government delegated titles and regulation. This is an incredibly important and complex area that needs legal attention.

There are thousands of groups that promote the educational credentials and accreditation of schools and degrees. Many of these groups also support the practice of their profession by non-degreed individuals.

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

The use of the least restrictive regulation is important to protect consumer choice, avoid using scope of practice laws, avoid defining CAM and practices, use including but not limited to language, don't use the word medicine, use the word health care.

Minnesota has designed laws well thought out over the last eight years that makes it possible for consumers to access all healers, unlicensed and licensed, in a safe manner. Consumers get really extensive information from their practitioners. Practitioners can practice across many disciplines, but must abide by safe and professional conduct. Consumers have a clear, quick recourse for complaints. Don't get caught up.

One last thing I will say is pluralism. Federal homogeneity should be reserved only for those

situations of harm. Consumer expectations are based on location and culture in which they find themselves. That is the beauty of culture.

Pluralism is an important component of a strong society. Free expression of rituals and traditions make for a rich culture.

DR. GORDON: Thank you.

Susan Bonfield Herschkowitz.

MS. HERSCHKOWITZ: My gratitude to the Commission for giving me this opportunity to speak. It is welcoming that conventional physicians are beginning to embrace and even be trained in natural medicine, however, it is misguided if the conventional medical community sees natural therapies through the prism of conventional medicine. There are major differences between the two that must be acknowledge and incorporated into current and future approaches to our nation's health care.

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

patient's body.

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

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

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

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

Natural medicine is low tech and less expensive than conventional medicine, but appears to cost more

because it is rarely covered by health insurance.

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

Unfortunately, the conventional medical community remains skeptical and dismissive of natural medicine's benefits. The Commission can erase the skepticism by becoming energetic partners with natural health care providers and their respective professional associations during its deliberations.

Natural medical experts have the knowledge and skill needed by the Commission to complete its work. Their professional associations work diligently to develop standards of training and care. The Commission would serve its purposes more effectively and wisely by tapping onto this wealth of experience.

Thank you.

DR. GORDON: Thank you.

Questions from Commissioners? Joe.

DR. PIZZORNO: A question to Susan Silver. How much of your curriculum is part of the core curriculum required of medical schools, and how much of it is electives?

MS. SILVER: It is virtually all elective at this point because it is a pilot, and we were not able to impose a further burden on the existing medical students.

The exception will be in the final module where they are actually participating with our own providers in our clinic, and they will get some elective credit for that, but the goal, of course, is to combine it with the core curriculum and have it become a part of that in the future.

DR. PIZZORNO: How many hours are you doing?

MS. SILVER: Well, the first module is really a treatment module, so it will consist of 12 treatment sessions after an assessment of the individual students' needs and goals, and so on, to enhance their health.

Our hope, in fact, and we will measure this, is that the students who are notoriously compromised in their health as they go through medical school will incorporate some of these practices into their own lives,

and we will measure, in fact, whether they maintain a higher level of wellness than their classmates who are not participating.

The didactic sessions will be about 15 hours in the second module, and the third module, the participatory module, is about two weeks spent in our clinic and participating in case management sessions and team meetings, that sort of thing.

DR. PIZZORNO: Just one more question. Are they given any training in how to work collaboratively with licensed natural medicine practitioners?

MS. SILVER: Well, we don't have a naturopath in our team, however, our clinical team consists of 13 different practitioners, so they are going to be exposed to a whole variety of CAM providers.

If someone expresses interest particularly in naturopathy, we will facilitate that, but as it is, they will get herbal experience and traditional Chinese medical experience, as well as mind-body techniques and bodywork, and so on.

DR. GORDON: Tom, then Joe.

MR. CHAPPELL: Robert, you brought an

interesting issue to light for me. Is the fact that information is not available to medical doctors, one, that they don't know how to find the clinical data or that we are not recording the data as CAM practitioners?

MR. SCHOLTEN: I think the answer to that is both, but a good example of what I was referring to, the World Health Organization has a database of some 8,000 adverse reactions to herbal products, which currently is not accessible to any researcher unless you physically go to Sweden to look at it.

They are also working on a classification for the therapeutic indices for herbal medicine, but I know that this initiative is cash poor and that they are desperately looking for help from the United States research community, so they can continue and complete that process.

I think those are just two excellent examples of data that is already in existence or is trying to come into existence where we could help if we had the infrastructure in place to do so.

In regard to the second part of your question, I think we could look at data, for instance, that exists

in Germany on the prescriptions of herbal medicines. There are millions of prescriptions that have been given to German citizens and presumably recorded, their outcomes are recorded, and to the extent that people can speak German, that information is helpful, but perhaps this is information that needs to be translated and made available to the English research community.

DR. GORDON: Joe.

DR. FINS: This is for Ms. Silver. Based on your knowledge of this undergraduate medical education, in your estimation, how much curricular time would be required to achieve the kinds of minimal standards that we articulated in our recommendations earlier this afternoon?

MS. SILVER: I will probably know the answer to that better after we have tested this a little bit. I described the length of time that we are expecting students in our project to spend, so I would expect that it will be that much time or perhaps --

DR. FINS: But you are talking about an elective, right?

MS. SILVER: We are talking about an

extracurricular activity.

DR. FINS: I am talking about balancing the curricular restraints in a medical school with what you ideally would like them to know, what is the package that you think would be viable in your institution.

MS. SILVER: I don't have the answer to that yet. I think that we have to pilot this program and get a better sense of the starting points of the students and the outcomes, and we will do that.

We are testing their knowledge and attitudes all along the way, along with our wellness, and as the progress through medical school, I think we will have a better idea from the survey instruments we are using, as well as just feedback, whether they think that they are getting a balanced exposure that will be significant and sufficient for them as they go on and practice medicine or whether they would endorse a more comprehensive approach, but I don't think we know the answer to that yet.

DR. GORDON: Effie.

DR. CHOW: Thank you. I really enjoyed the presentations. Rustum Roy, of course, our discussion has

been all on sort of the professionals, and so forth, and I am interested in that.

Now, are you talking about public education or are you talking about specifically children in school, or can you elaborate on that?

DR. ROY: Yes, I think I shouldn't have said the other half, it's the other 99 percent. Really, the opportunity is enormous, and I mean using the formal systems. We now have through the web, through Andy Weil's lectures or Deepak Chopra on TV, education gets out, but I think, in fact, we should formalize that in college. We are giving a course in Penn State this semester. We will be doing it at Arizona State next fall for the general student. Under the science education, what science should people get? They learn about astronomy, but they don't learn about their own health, it's ludicrous.

So, I am talking about doing it K through 12. We know that system at Arizona State. We have the biggest science education effort in the country. We know how to get it in through K through 12 and in college. That is what I think is our new system.

You guys are doing it anyway through all the informal channels. I want to formalize the education of the citizen-patient. It is a very cheap program compared to less than one drug development will be for this enormous mass of citizens at all levels of the economy to get some information about alternatives.

DR. GORDON: Don.

DR. WARREN: For Diane Miller. Is the Minnesota model working?

MS. MILLER: We don't know yet.

DR. WARREN: How long has it been in existence?

MS. MILLER: It hasn't gone into existence.

DR. WARREN: It hasn't gone into existence yet.

MS. MILLER: July 1st is when the office opens.

DR. WARREN: So, we really don't know if this idealistic model will work or not.

MS. MILLER: Right. This statute was based on a statute that is 15 years old in Minnesota, and it has been used for unlicensed mental health practitioners, and we are the only state with an unlicensed practitioner statute. That is the statute that it is. So, they already have an office that has been functioning really

well for 15 years, and they like the statute. So, that is why the Department of Health study on CAM recommended that we use that model of legislation because it works so well.

DR. GORDON: Any other questions?

[No response.]

DR. GORDON: I have one comment and one question. The comment is -- and this is for everyone on this panel, as well as in the audience -- at our next meeting on March 26th and 27th, we will deal with issues specifically of public information, which many of you are raising here on this panel, and also issues related to wellness, so the 26th will be public information, the 27th will be wellness.

I have a question for Rustum Roy, which is do you have a step by step plan that you could provide us as a guideline for formulating, perhaps formulating a recommendation to the National Science Foundation, Department of Education?

DR. ROY: Either the Department of Education or jointly with the Public Health Service, I will be happy to provide you with that, at least what worked in the

past in my political experience in Washington. I think that is a very viable one, and the National Science Foundation would be eager to take it, or the Department of Education, not favoring anybody. I don't think it is an NIH kind of thing. It is not a research thing.

But in the education side, we have a lot of track record, we know how to do it.

DR. GORDON: So, anything that you could provide us that would give us guidance, because one of the issues that we deal with here is as we are getting ready to make recommendations for our interim report, is acceptability and feasibility.

I am asking this of you in particular, but also of others who come on the panels, if there are thoughts that you want to give us, and I know when we go to Minnesota in March, we will be hearing a lot more about how you implemented the Minnesota Act and what organization was necessary for that. But any information any of you can give us about implementation, feasibility, political hurdles, support for different proposals that you have, that will make our job a lot easier in terms of making recommendations.

DR. ROY: Jim, I would be happy to send you my version.

DR. GORDON: Great. Charlotte, did you have your hand up?

SISTER KERR: I had the exact same question of Dr. Roy, as well as, do you know who anyone who implemented this, particularly K through 12, any program?

DR. ROY: On health.

SISTER KERR: For the citizen-patient.

DR. ROY: Zero. That is what we have been looking at, at Arizona State. We don't know of anything remotely like it, and we are puzzled. We used to have health education. It became phys. ed., then, it became sex ed., and all that, but here is this whole world. Our dream is globalization of the information base, something like the Harvard Group wanted, the globalization of knowledge.

Every student is so eager for this stuff, they are interested, and it is relevant to the citizenry, it's the only thing that is going to lower costs, why Congress likes it, it is the one hope on a massive scale to cut that 10 increase in HMO costs every year.

DR. GORDON: Diane, did you want to make a comment about that?

MS. MILLER: I did. We have a junior college that has part of it as their curriculum for general students as, you know, alternatives in CAM and what their impacts are, and also there is a bill before our legislature to take pop machines out of the school. I just thought I would tell you that.

DR. GORDON: So, we would welcome, if there is a curriculum that you think would be interesting for us to look at, please send it, and Robert Scholten, if you have come up with anything in that area, too, we would really appreciate it.

SISTER KERR: And also anyone that you may know. We heard of an example this morning from Berkeley of taking the sodas out, changing the food, and Beverly Hills -- I keep saying Berkeley, I think of Berkeley as the sixties, you know -- but any of those models we would be very interested in receiving.

DR. GORDON: Thank you very much.

MS. CHANG: The next group of speakers, if you could please come up at this time, and that would be

Michele Forzley, Victoria Mary Goldsten, Brenda Jasper, Emily WhiteHorse, Bruce Nordstrom, and Brian McAulay.

DR. GORDON: Michele Forzley.

MS. FORZLEY: Good afternoon, everybody. I always feel like we leave the international arena until the last of the day, and here I am again at 5:00. I am not going to speak from my written remarks because I have decided that it is not going to be very helpful for you at this moment.

When I left the office at 3:30, having finished writing them since lunchtime, I thought, oh, I have got it all figured out, but no, indeed, I didn't get it on paper as well as I would like to. So I am going to look at your Question No. 1 on your sheet of instructions to speakers, and it says, "Can uniform standards of education, training, licensing, and certification be applied to all practitioners?"

No is the answer. You will never get it through politically because every state is not going to relinquish its control over the regulation of medicine, it doesn't happen. Europe tried to come up with uniform standards across national lines. They didn't succeed.

Instead, they came up with a system of harmonized standards.

This is the same thing I mentioned to you the last time I was here in talking about access and delivery, and a harmonized standard allows for some level of uniformity, if you want to call it that. It allows for some general guidelines to be developed by commissions such as yours to seek to achieve some level of credibility, competency, et cetera, whatever you think are the goals of those standards, yet, permitting the states to come up with their unique brand of whatever they think it is. Okay?

It is going to be very difficult to divest states of their power, particularly medical boards, right?

Next, there is a larger community that will be benefitted by your work in this regard, and that is the health care community as a whole, never mind the CAM practitioners who you are first to address. Doctors, nurses, and all health care professionals suffer -- as do lawyers, by the way -- and other professionals from the requirements of state licensing that differ from state to

state. It is not licensing generally, but it is licensing from state to state.

Now, we have to worry about the advent of telemedicine, which is practicing electronically on internet. So, where can you look for some guidance?

Number one, the Europeans in 1992 wrote Directive 51, which came up with a whole system of harmonizing education and training.

Number two, you can look at the International Treaty on Telemedicine, which I wrote, along with Committee 2 of the International Bar Association, which seeks to do this internationally, so that medicine can be practiced electronically.

Third, there is a tremendous body of work which identifies the equivalencies in education and licensing standards between states within the United States. The work is done by Alternative Link, Incorporated, who I am sure has presented here before, so there is no need for you to figure out what the equivalencies are.

You need to come up with what method of harmonization you are going to employ, what rules you will follow to accomplish that.

Lastly, don't forget to teach people about how to run a business, because that is what is going to make the success of a CAM practice, that they know how to run a business, because that is what it is until we come up with a system of reimbursement that provides enough money for CAM practitioners to do what they do well, and why people go to them. It isn't going to pay for them to have a seven-minute acupuncture session.

So, until then, they are running a business. Thank you.

DR. GORDON: Thank you.

Victoria Mary Goldsten.

MS. GOLDSTEN: Thank you.

Hello. I am Victoria Goldsten, a Registered Doctor of Naturopathy, licensed massage therapist, and licensed nurse in Washington, D.C. I also practice in the State of Maryland. I am here on behalf of traditional naturopathy across the United States.

As traditional naturopaths or true naturopaths we treat the human condition with naturally occurring substances such as homeopathics and herbs. In addition, we use physical modalities such as our hands and voices

in a variety of treatments such as guided imagery and acupressure.

It is important for the Commission to know that true or traditional naturopathy does not cross the line into conventional medicine and prescribe conventional drugs or perform minor surgery as medical doctors and naturopathic physicians do. We as naturopathic doctors and naturopathic practitioners are strongly against this process for this is the job of qualified medical doctors.

The directors of the American Naturopathic and Holistic Association and the Washington Institute of Natural Medicine in the D.C. metro area, the College of Naturopathy in California, and the College of Metaphysical Studies in Florida also wish to convey to you that this is their opinion as well. The general consensus of traditional naturopathic schools and service organizations is freedom of choice by the consumer.

We, as traditional or true naturopaths, have a strong commitment to health care. In this promotion of health care, it is extremely important that we continue to be afforded the right to continue our practice. In order for this to happen, we respectfully request our

federal government strongly support broad guidelines in educational licensing and professional licensing process.

Educational licensing must allow for vocational schools, degree programs, and most importantly, apprenticeship training in naturopathy. It is of utmost importance that the apprenticeship component not be overlooked. This style of learning provides a hands-on component like no other. We would like to see this style of program not be eliminated and not be under the same stringent guidelines of higher educational facilities. Apprenticeship training creates affordable, safe, compassionate, and experienced practitioners.

Here in Washington, D.C., the educational licensing commission has forced an apprenticeship program in naturopathy to shut down based upon a newly enforce D.C. requirement that the program meet the same standards of vocational schools or colleges.

At its inception, the program was informed by the District that it could function under the exempt category due to its apprenticeship status. In the neighboring states of Virginia and Maryland, a friendlier approach has been adopted, allowing apprenticeship

program to fall under the exempt category.

We wish to see these states as examples for all states across the nation. If overly restrictive licensure eliminates this apprenticeship component, affordable and accessible natural health care will not be available to all of those who need it and want it.

If strict licensure eliminates this apprenticeship component, the good of the general public will not be met.

Thank you.

DR. GORDON: Thank you.

Emily WhiteHorse.

MS. WHITEHORSE: Good afternoon. My name is Emily WhiteHorse. I am here on behalf of the Association of Physician Assistant Programs. As a PA practitioner and educator who has embraced the inclusion of CAM for over 10 years, it is truly an honor to be here today in the presence of this distinguished committee.

There are approximately 40,000 practicing PAs, 10,000 PA students, 126 accredited programs. Over the past five years alone, the number of PA programs has doubled.

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

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

Evidence supports there is a fundamental change occurring in the values, beliefs, and expectations of the people who make up our culture regarding health, healing, and disease.

Health care systems are developed around and function from an explanatory model, which is culturally bound and based on the overall beliefs and values of the culture.

Clearly, we are on the brink of change. Our

culture is redefining its beliefs and expectations of health care, health care practitioners, and the entire health care system. It appears that this paradigm shift represents a world-view shift from a mechanistic, reductionist one to a holistic one.

While it is important to focus on identifying and understanding CAM, we also need to ask the questions: what is it that our patients really want from us as providers and from our health care system?

If they are asking that we become more holistic in our overall approach to health and illness, then, does our job as medical educators become the integration of holistic concepts and principles into the educational model of health care practitioners, concepts which include CAM?

A first step could be the creation of a committee or task force to address these and other concerns facing the education of medical practitioners as a whole. In the spirit of holism and cross-disciplinary cooperation, this task force could bring together educators and practitioners with the goal of establishing minimum requirements for all of medical education