regarding CAM. A need for clear and consistent guidelines and consensus seems warranted.

All of this, however, rests upon whether CAM is included as an acceptable standard of care in our health care system. Without support from organizations like NIH and this commission, and continued national and government support and recognition of the potential CAM holds, its inclusion in medical education as an accreditation standard and program curricula or on board exams remains uncertain.

As a result, future practitioners will continue to struggle in the same way that we as practitioners today struggle with the lack of formal training regarding CAM.

In closing, I would like to thank the commission for the opportunity to speak on behalf of APAP, and to also offer our assistance and cooperation in future deliberations of this important issue.

Thank you.

DR. GORDON: Thank you very much.

Brenda Jasper.

MS. JASPER: Thank you. On behalf of the

Association of Physician Assistant Programs, the only national organization in the United States that represents PA educational programs, I thank you for this opportunity to share our educational model as an example of integration of CAM into existing educational programs.

APAP's mission is to assist physician assistant educational programs in the instruction of highly educated PAs in numbers adequate to meet society's needs. Physician assistants are health care professionals licensed to practice medicine with physician supervision.

As a part of our comprehensive responsibilities, PAs exercise autonomy in conducting histories and physicals, diagnosing and treating illnesses, ordering and interpreting tests, counseling on preventive care, assisting in surgery, and in most states, writing prescriptions.

The PA profession grew out of a recognized need for educating health professionals that were trained in the medical model that would work with physicians and extend access to care, particularly in medically underserved areas and health professions shortage areas.

The curriculum in PA educational programs is

geared toward primary care and focused to provide the appropriate education in an intensive and uniquely designed manner. Over the profession's 35-year history, we have established educational accreditation, national certification for practitioners with support of the National Board of Medical Examiners, the AMA, the American Academy of Family Physicians, and the American College of Surgeons, and the American Academy of Pediatrics.

Although all accredited programs must meet the same rigorous educational standards, they have the flexibility to offer a variety of academic degrees. Implementation of core curriculum is flexible within all of the PA programs. What a physician assistant does varies within training, experience, and state law.

In addition, the scope of practice for PAs corresponds to the supervising physician's practice. Referral to the physician or close consultation between the patient, the PA, and the physician is done for unusual and hard-to-manage complicated cases. Physician assistants are taught to understand their limitations as an important part of PA education.

PA education is tightly structured and focused, and is recognized by many as innovative, efficient, and effective with an average of two years prerequisite education, 25 to 27 months of didactic and clinical education.

The accreditation standards have historically embraced the latest innovations and trends in medical practice over the years, and to add to our rigorous curricula content areas such as multicultural impact on care are included in our educational model.

DR. GORDON: Thank you very much.

Brian McAulay.

DR. McAULAY: Thank you for the opportunity to share information with you about chiropractic education, its state, and how the profession can best serve the American people.

I serve as president of Sherman College of Straight Chiropractic in Spartanburg, South Carolina.

Chiropractic is based on the premise that the body's innate physiologic capabilities are affected by and integrated through the nervous system. Chiropractic is a science and art devoted to the location, analysis,

and correction of vertebral subluxations. These are misaligned vertebrae of the spine that interfere with the ability of the nervous system to control and coordinate the various organs and systems of the body.

Many health-conscious people make chiropractic a regular part of their health care regimen, along with such other sound practices as exercise, good nutrition, and stress management. Chiropractic is a separate and distinct field that does not compete with the practice of medicine nor the use of alternative therapies.

The education required to become a licensed Doctor of Chiropractic is rigorous, it is similar to that required for M.D.'s. All students entering chiropractic college must have completed 90 semester hours of prerequisite courses at an accredited undergraduate college. That is the equivalent of three years.

Once enrolled in chiropractic college, students complete approximately 4,600 hours of instruction. This is typically accomplished through approximately 13 academic quarters, requiring three and a half years of full-time study and residence, or the equivalent of five years of study at a traditional semester system.

The chiropractic profession has grown and prospered in this country based on the public's demands for these important services. The profession has traditionally received limited federal support.

For that reason, I recommend the Commission pursue the following initiatives to ensure the availability of quality chiropractic care for the American public:

First and foremost, I believe we ought to formally recognize the value and appropriateness of chiropractic's meta-therapeutic health care paradigm that focuses on enhancing performance and function, rather than treating diseases or conditions.

Second, I would like to see us provide student loan and debt relief for chiropractic college graduates who practice in underserved areas of the country or care for underserved segments of the population.

Thirdly, I think we ought to provide direct federal funding to support chiropractic college education with investments in facilities, training, and technology, as is currently done in the nation's medical schools.

Chiropractic colleges must benefit from such

national initiatives as Congress' approved doubling of the NIH budget from 1999 to 2003 to ensure qualify education of a far greater spectrum of the nation's health care providers.

Lastly, I would like to see federal funds allocated for chiropractic college-based research programs. Supporting the paradigm of chiropractic research that explores ways to help people avoid serious health problems and enjoy greater function and performance compared to traditional biomedical research would help reduce our nation's dependence on expensive medicine interventions once disease states and conditions have manifested.

DR. GORDON: Thank you.

Bruce Nordstrom.

MR. NORDSTROM: Thank you for the opportunity to be here this afternoon. My name is Bruce Nordstrom. I am a practicing chiropractor in the District of Columbia.

The American Chiropractic Association has submitted to the Commission detailed information on the issues being discussed here today. I would like just to

highlight some of those issues.

In developing policy recommendations to Congress, the American Chiropractic Association encourages the Commission to consider the following:

All CAM providers should be held to equivalent criteria as other licensed health care providers in the areas of education, licensure, oversight from licensing boards, and public opinion.

Care must be taken that the principles of each CAM practice be maintained and not supplanted by allopathic philosophy. As an example, prevention and wellness are principles of the chiropractic profession, and should be utilized as cost effective mechanisms as they have been shown to be in the past, and not discouraged.

All CAM providers who have direct access to patients should possess the ability to differentially diagnose and refer to and/or comanage the patient's treatment if the condition is beyond the scope of their expertise.

Students studying at accredited CAM institutions must be provided the ability to observe and,

where appropriate, comanage a broad spectrum of conditions and/or diseases as is typically seen in teaching hospitals.

While some chiropractic colleges and medical teaching institutions have had occasional collaborative activities, typically, there is a lack of cooperation from the medical institutions. This is particularly egregious given that most of these institutions are support by state and federal taxes.

These public institutions should provide any accredited institution, traditional or CAM, the opportunity to broaden the student practitioner's knowledge and clinical expertise.

Any guidelines utilized for CAM, whether condition- or modality-specific, must be developed through consensus by the profession, and reflect mainstream practices.

It is imperative that guidelines be treated as such, and not as absolute limitations on services. Unfortunately, this currently takes place with many third party payers. The ultimate judgment regarding the propriety of specific procedures must be made by the

practitioner in the light of individual circumstances presented by the patient.

Thank you, and we stand ready to help wherever we can.

DR. GORDON: Thank you for coming again and for your testimony.

Questions from Commissioners? Joe.

DR. PIZZORNO: This is to either of the ladies from the APAP. How many hours of CAM education are you providing, and what are you actually accomplishing with that education, what are you trying to accomplish?

MS. WHITEHORSE: In a study that I did in 1998, to look specifically at what we were doing in the education field in terms of CAM, the average or the mean number of hours spent by the 80 programs that responded, of the 107, was an average of 4.5 hours. The range ranged from 1 hour to a total of 60 hours.

The presentation of that material varied. Most of the times it was in lecture format. The other thing that is important to know that one of the things I differentiated in that study was whether it was considered formal education versus elective, formal

meaning that it was in a required course, attendance was required. So those numbers that I am giving you reflect formal rather than elective.

In terms of the topics, one of the things that was submitted to the Commission, it lists all of the modalities that were covered. There was no consistency to any of them, it really was program-specific, faculty-specific, which is one of the things that we are trying to work on and ideas that we can get from the Commission in terms of having some consistency for us.

DR. GORDON: Let's try to follow up on that for a second. Have you sent us that survey?

MS. WHITEHORSE: In the response that we sent t you from APAP, there are some of those statistics quoted, but I can certainly get you copies of the actual survey.

DR. GORDON: We would like to the survey.

MS. WHITEHORSE: Certainly.

DR. GORDON: I am not sure, you are asking for us to provide guidelines for what should be taught, or explain a little bit more about what you would like us to do.

MS. WHITEHORSE: I think that, as PAs, I don't

want to just talk about us as PAs because as part of the conversations that we had or I had an opportunity to sit in on earlier today, it is the whole issue of education and how do we incorporate this into the educational model. So, we are dealing with the same questions that M.D.'s are and other health care providers.

I guess my recommendation or our recommendation is to have some kind of a task force, which is somewhat what you are doing, is to come up with some basic guidelines, whether they be core competencies, core concepts, that we can follow in terms of establishing as an accreditation standard throughout all of PA education rather than it having one school teach it, one school not, so that there is more of a consistency.

DR. GORDON: You don't currently among the PA schools have that kind of task force operating?

MS. WHITEHORSE: No, we don't.

DR. GORDON: Any reason why not?

MS. WHITEHORSE: I think that the interest is beginning to come. I think the interest is there. I think some of the barriers that we run up against is that we have a very labor-intensive program, and the question

is where are we going to put it in the curriculum.

So, we are forced to teach based on our accreditation and our curriculum guidelines and standards, and in those standards, CAM is not in there, so we are teaching to our accreditation standards.

DR. GORDON: Thank you.

Don.

DR. WARREN: Dr. McAulay, did you say that you did not recognize CAM or did I misunderstand you?

DR. McAULAY: I hope you misunderstood me.

DR. WARREN: Okay. That was right at the first of your talk. It just kind of caught me off-guard.

DR. McAULAY: No, I am sorry if I misled you in that way.

DR. GORDON: Linnea, is your hand going up?

MS. LARSON: This is real quick. Thank you for your testimony in December, Michele, and thank you for today. I do not recall if you gave us the material in December about the harmonization policy and how long that took for the European community to come up with, et cetera, but I would really like you to give me a brief understanding of how long did that take.

DR. GORDON: I would like to add to that also. I would like to get a sense of what kind of reception this concept gets.

MS. LARSON: That was my second question.

MS. FORZLEY: You mean reception from the Commissioners or from the European community?

DR. GORDON: If you are talking with different licensing boards in different jurisdictions, how does the notion of harmonizing appeal to them since there is so much desire for individual differences and for individual autonomy.

MS. FORZLEY: I am sorry, I can't answer that last question. I can tell you that in Europe, in 1992, the first directive was issued, and this is an example of how thick, how many pages the original directive plus subsequent amendments are.

Now, remember this covers all trades and professions to harmonize educational requirements over all trades and professions including health care professions, and it was specifically determined by what is called a Written Question to the Commission, in 1998, that it applies to CAM practitioners, which was very

interesting. It is the first thing I found in my research on Europe.

So, this is an evolving process that is really founded in the reason why Europe has formed a common community, which is really based in trade, and what they are doing is they are effectively evolving into a federation as we are, as opposed to moving away from it. They are combining rather than dissembling.

So, we have a federal system that says what is federal, what is state power. They all had state power, and they keep moving towards what is federal, and they have left still to the states to determine health care policy and procedure, but because they have a principle that says we want to permit to work in France, and then they go work in Germany or wherever they want to work, we need a way in order for Germany not to say to a French whatever that he can't practice because his education, training, licensing, and credentialing isn't equivalent under the German system.

So, they came up with this very system, and it is the same system, by the way, that was adopted by the International Telemedicine Treaty, which is before the

World Health Organization, as a way to harmonize national scope of medicine practice laws, because most other countries do not have state scope of medicine definitions, they have national registration, because there is only one place you go.

Here, we have 51 states -- I never remember anymore -- 50 or 51 states, boards that approve you to practice medicine or nursing or whatever, but nationally, in most countries, it is one. So, we have a system to put them all together under one roof, so to speak, without taking the political power away from people who want to hold onto it.

So, I urge you to really look to a harmonizing system because I think you will spin your wheels on a uniform system. Personally, I believe that we should have a national registration system for all our professions, but do I think it is realistic in the next years, no, I don't.

If the ABA can't decide, if the American Bar Association can't decide that lawyers should practice across state lines, I doubt the health care professionals will agree to it either, but you can do something else,

which is really needed, and another benefit of this is that you will give the different associations representing modalities something to look at when they go to their state legislator to lobby for what they are trying to get.

They spend a lot of time and trouble trying to define what they are as compared to something else, and they don't have the ability, the competence, they don't have the money to pay for it, they don't have the political power to do it, so it is very difficult.

I think you would do a lot to help all of the modalities if you came up with a set of standards and guidelines as recommendations, guidance.

DR. GORDON: Linnea, did you want to follow up on that?

MS. LARSON: Mostly, I wanted a little bit more clarity about the concept than the definition of harmonization. I think you did kind of provide that in the testimony in December, but it is a concept which is based on trade, the ability to do trade throughout the European community.

MS. FORZLEY: Well, it's the right to work. It

says that I have the right to work in D.C. and in Maryland, if I live here, and Virginia, and that is probably important for me if I work here. I am confronting it myself. I just moved here. I can't practice in Maryland or D.C. or Virginia because I am not licensed here. I have to go take a bar exam in Maryland, I have to pay lots of money to three states to get licensed.

Okay. Well, so that's the same thing that happens to a doctor or a nurse or anybody, and it is going to happen to CAM practitioners. The European community was based on a concept of trade, free trade, rather than what the United States was based on, which was really freedom, personal freedom, which I think is important to remember that consumers are driving the CAM revolution, and it is based upon their consciousness, of their ability to choose what they want to do, and because we have this presence of consciousness today, it is happening and despite what we may want to do.

So, we have to look at how are we going to allow it to happen, how are we going to not impede it in some way. Now, the other side of the coin is the right

of the person to earn a living, which is also what it is about, and my right to select who I have heal me. That is where I think our personal freedoms come in based on our system.

I hope I have answered that question for you.

DR. GORDON: I think there is still another piece, and maybe you can just provide this in writing. What is harmonization?

MS. FORZLEY: Well, it's not -- let's look at what is uniform. Uniform says that if I am, let's say, an acupuncturist, I have to have X education, Y training, Z experience, and I pay a fee, and I go through this procedure to get licensed in State A.

If I have a harmonized system, I have something that says to State A and State B you must write a law that says you have to have a maximum of this. You can write a law that says you can have less than this, but you can't make them have more than this.

So, it is setting sort of a roof on what the states can say they must have. So, a state can say, well, you know, you only need two years instead of the required three if you want to practice this or that, but

the national guideline or harmonized rule says you have got to have three, and that is really where I think your value is as a commission, is because you have this overview of what they all should have.

DR. GORDON: If you could provide the specifics of that at least for health care, that would be very -- do you want more than that, Linnea?

MS. LARSON: I wanted the clarity of the definition, then, an example. That's all.

MS. FORZLEY: Is that enough? Do you understand?

DR. GORDON: It would be great to have it in writing, whatever you have in that sheaf of papers that could help us.

MS. FORZLEY: Okay. I just want to point out to you that there are established international principles of law, sort of interpretation of law, that are called Rules of Harmonization.

I can give you a textbook on it.

DR. GORDON: Well, maybe a few pages, a Cliff Notes version.

MS. FORZLEY: I will try.

DR. GORDON: Thank you.

MS. FORZLEY: And thank you all.

DR. GORDON: Joe.

DR. FINS: I just point out, being patriotic, that we have had a single currency in this country for more than a year, but I do want to ask the folks from the PA universe how they would respond to a hypothetical, a PA, who is a physician assistant, decides to work for a naturopathic physician in Washington State, would that be a deviation from your ethical norms, would that be adequate supervision? How would your organization view that individual?

MS. JASPER: First of all, it is based on the state legislation as to whether a PA can practice in that state under a naturopath that would determine whether we could. PA practice is generally guided by the physician that they work with, and our duties are determined by the agreement that is reached between those two practitioners in terms of our skills and our expertise.

DR. FINS: Just to follow up, to bring up the issue of harmonization again, suppose there was a kind of a dissonance in training, there was an overlap, for

adequate supervision, would that concern you?

MS. JASPER: No, I don't -- because PAs are taught to, first of all, understand our limitations and to accept where we don't understand what we know, and say "I don't know," and be able to make decisions as when it is appropriate to refer and to seek consultation and guidance.

DR. FINS: I think it is an interesting question. We have a changing definition of perhaps what physician is under some state laws. Your mandate is really, the presumption is that you are going to work with a conventionally trained physician.

MS. JASPER: An M.D. or a D.O.

DR. FINS: Right, exactly, and naturopathic physicians in some jurisdictions are called physician, so they present a problem.

MS. WHITEHORSE: Your assumption is correct, that the model that we function with is really conventional and really is biomedical, and when we say that we work with physicians, it generally is an M.D. or a D.O.

I don't know that we have actually ventured

into PAs working with other providers that also use the term physician, as you alluded to, with a naturopath. I think that that is going to be an up and coming issue for us as a profession, especially based on what the recommendations of this Commission are in terms of recognizing other practitioners of health care, but presently, it is really M.D.'s and D.O.'s, and if a PA practices an alternative modality.

For example, in the State of Pennsylvania, it is right in our laws and our regulations that we cannot do acupuncture. I mean that is actually specifically outlined. Now, that is for our state. For another state, you know, when the Board of Medicine sat down to write up our guidelines, they specifically said for some reason that we couldn't do that.

So, it is somewhat state to state regulated, but to the best of my knowledge, it is M.D.'s and D.O.'s.

DR. FINS: I just think it brings up a whole other category of professionals who work under supervision, who are related in their responsibility, their liability to the person who is prescribing, a nurse who is conventionally trained, who works under a CAM

practitioner or PA, so it is a whole other level.

It would be helpful to us if you could simply take this hypothetical and think of responses and ways you would address it and ways that we might be able to maximize utility and minimize the down side, because I think it would be instructive for other hierarchical supervisory relationships between different kinds of professions.

DR. GORDON: You had a question, Tom?

MR. CHAPPELL: Yes.

DR. GORDON: Go ahead. I am sorry, didn't see your hand.

MR. CHAPPELL: I am sorry, I thought the Chair had recognized me. I have a question on physician assistants.

At the present time, your role as a physician assistant in a clinic would be to receive the patient and maybe provide some care, but may also refer to a physician within that clinic, is that correct?

MS. JASPER: Yes.

MR. CHAPPELL: So, if you were trained with sufficient core competencies in the knowledge of CAM

practice, and that clinic was integrative, do you see yourselves being able to be in a role in which you could continue to refer to any array of practitioner in that integrated clinic? Would you see that as a competency that would be appropriate to the role and standard of a physician assistant?

MS. JASPER: We have discussed that, and we feel that that would be most appropriate as primary care providers, that there is a general core standard in our accreditation guidelines for PA education that would say certain things must be included.

It may vary in programs because programs have the individuality of determining how it is integrated into the curriculum. Therefore, the PA, based on its actual practice, could then determine the level of their practice and the level of their responsibility for making those referrals.

MR. CHAPPELL: And so it's possible.

MS. JASPER: It is, yes.

MR. CHAPPELL: Thank you.

DR. GORDON: Any other questions?

[No response.]

DR. GORDON: Thank you.

MS. CHANG: Our final group of speakers, if you would come up, please. David Molony, Kathleen Quain, Shula Edelkind, Colleen Smethers, Christina Walker, and Dr. Chi Chow.

DR. GORDON: Thank you for your patience and perseverance. David Molony.

MR. MOLONY: Good afternoon, Commissioners. My name is David Molony. I am an Oriental Medicine professional and the Executive Director of the American Association of Oriental Medicine.

The Oriental Medicine profession is, by far, the most comprehensive, far-reaching, credible, and accepted CAM field of medicine in the United States. We have, in place, national education, accreditation and certification examination standard in acupuncture, herbal medicine, and bodywork.

The training for the majority of new practitioners is a comprehensive three- to four-year program, with the graduates having a solid grasp of our entire field, and the capability to refer within that field.

This, combined with a level of conventional medical training that provides them with the capability to refer to general, specialist, or hospitalist conventional practitioners as appropriate, rounds out the training.

Due to the continued improvements in our education and the history of low claims, our malpractice rates for a $1 million/$3 million policy have dropped steadily to less than $650, about one-third of what they were 10 years ago.

The demand for our services becomes obvious when one looks at the other fields of medicine grasping for patient share, bypassing our recognized and accredited educational programs in favor of abbreviated continuing education courses that do no provide the knowledge, skills, and abilities needed to achieve the consistent outcomes that we have come to expect from our field.

It is easy when a biomedical or chiropractic physician fails to diagnose or treat properly with acupuncture due to this limited training to fall back on the very things the patient has come to acupuncture and

Oriental Medicine to avoid, namely, drugs, more chiropractic, or surgery. How many patients have trusted their minimally trained CAM doctors to later become disenchanted with the results, thinking that it was the acupuncture that failed? Acupuncture is not continuing education, it is continual education.

We have fully entered the modern world of credibility, liability, and responsibility, with educational standards, practice guidelines, regulatory oversight by our licensing boards, and the professional peer review process that all provide overlapping avenues of accountability to the consumer.

While there may be some place developed by all professions working together for intercollegial trade of aspects of our prospective fields, there must also be respect for a comprehensive education in each. In this scenario, there must be ethical boundaries shared to develop a knowledge base of what is best for the patients.

We hope that you all reflect deeply on the facts and concerns expressed in this presentation here today, as it is your commitment to our country and to the

people of United States to do what is best, beyond the many strong currents pulling you in many directions.

I would like to thank the Commissioners for their hard work and their ready humor.

DR. GORDON: Thank you.

Kathleen Quain.

MS. QUAIN: I am a psychotherapist, social worker, president of the Foundation for Health and the Environment, and I direct.

Through education, people can learn to live with more health in their daily lives. Through policy and communication that supports prevention --

DR. GORDON: Could you come a little closer to the mike, too.

MS. QUAIN: Sorry. I have a design that matches what you are saying you need, so this is part, the curriculum, and I have this master plan for health, that I don't know where it goes, so I am just telling you that.

So, through education, people can learn to live with more health in their daily lives. Through policy and communication that supports prevention, we can stop

health problems before they happen.

For example, preventive measures for diseases such as breast and prostate cancer should be public knowledge. Health insurance companies could tap a huge untapped market if they covered prevention.

CAM practices and interventions could be reimbursed through a federal program that develops health, carries the concept of waste reduction as a respected way of thinking to the populace, and employs collective stress management techniques to reduce violence.

Through television that is designed to create health, the media, media outlets, health channels, and information technology, health could be organized and disseminated as a popular and effective outreach.

State-of-the-art television programs could be developed to create positive results within mainstream populations. Health-based programming could replace horrific images that children see now within the media. Scientifically based imagery could facilitate healing where healing is indicated. Elementary through high school health education could incorporate prevention to

directly reverse the violence crisis that has become evident within our childhood population.

A new report entitled "In Harm's Way" published by Greater Boston Physicians for Social Responsibility, in partnership with the Clean Water Fund, says that millions of children in the U.S. exhibit learning disabilities, reduced IQ, and destructive, aggressive behavior because of exposure to toxic chemicals, including pesticides during early childhood or even before birth.

The report states that neurodevelopmental disabilities are widespread, and chemical exposures are important and preventable contributors to these conditions.

"In Harm's Way" reviews scientific and medicine information on a range of toxins to which most or all American children are exposed, and draws links between them and to the rising number of children diagnosed each year with abnormal brain development or function.

The gospel of peace teaches us to detoxify our bodies so that the Spirit of God can go inside of our bodies and we can feel peaceful. To sustain our souls,

all public policy must consider the injury to our health from the misuse of toxic pesticides.

CAM practice and intervention could be applied to public health threats, such as the West Nile Virus. An economical, safe, and national preventive treatment program could combine technology that supports human nature and the health in nature.

The U.S. Coast Guard has successfully used the Mosquito Magnet when toxic pesticides were not effective on the mosquito-infested islands.

DR. GORDON: We are going to have to ask you to stop.

MS. QUAIN: Okay.

DR. GORDON: Do you want to have a concluding sentence or two?

MS. QUAIN: Yes. I just wanted to say that the Pope's message last week spoke of nature's intrinsic value and that, above all, nature's metaphysical concept has been forgotten.

Thank you.

DR. GORDON: Thank you.

Shula Edelkind.

MS. EDELKIND: Colleen Smethers and I are together, so I would like to let her go first.

DR. GORDON: Are you Colleen Smethers?

MS. SMETHERS: I am.

DR. GORDON: Whichever way you would like to do it.

MS. SMETHERS: My name is Colleen Smethers, and I am here on behalf of somebody else, Karen Scott, who testified before this commission at a town hall meeting in Sacramento in September of last year.

She was asked to come back with more information, and her chronically ill condition did not allow her to come today, so she has asked me to read her statement.

Her statement of September is in Section 3 of our somewhat large handout that we gave you.

Her statement is: Can accredited medical schools routinely teach courses in progressive and alternative medicine and have a physician lose his license for correctly applying what he learns? The answer is absolutely yes.

As an example is the case of San Francisco's

Dr. Robert Sinaiko, a respected board-certified allergist and immunologist, who was using the latest advances in medicine to help people suffering from multiple chemical sensitivity, chronic fatigue, ADHD, and autism.

Despite this doctor's excellent record of improving quality of life for these patients, and despite the fact that no patient was harmed or complained, his medical license was put under such restrictive probation by the California Medical Board, he was forced to close his practice.

In Dr. Sinaiko's Medical Board hearing, the prosecutor insisted that no research supported Dr. Sinaiko's treatments. They completely ignored the studies presented from mainline, peer-reviewed medicine literature.

The Medical Board instead followed their own experts offering no supporting evidence. The Medical Board of California has arrogated to itself the right to decide which medicine they prefer, based not on scientific fact, but on opinion. Both the California Medical Association and the Center for Public Interest Law have written amicus briefs supporting Dr. Sinaiko's

case and protesting the actions of the Medical Board.

From the California Medical Association's amicus brief, and I quote, "If the Medical Board just wants to get the doctor at any cost, this decision shows how it can be done."

The consequences to the doctor and his patients have been devastating. Dr. Sinaiko has had his reputation ruined and been assessed over $50,000 for the prosecution of himself, and he has been forced out of practice.

Many of Dr. Sinaiko's patients now are unable to find help for their medicine problems. In desperation, patients are having to travel out of state. Karen is one of those that has to do that. Without Dr. Sinaiko's care, many patients' conditions have worsened and many others describe their health as having substantially deteriorated.

Few physicians have sufficient financial resources to fight the state-funded Medical Board. Faced with a reputation in ruin, emotional devastation, and finally being required to pay the exorbitant cost recovery charges, most doctors just give up. The Board

wins by default whether or not this is a fair or legal process.

Strong federal legislation prohibiting state boards from setting the standard of practice and choosing sides in scientific controversy, as well as declaring cost recovery unconstitutional is urgently asked. As the system stands now, it is clearly open to abuse. Every day, doctors and their patients are paying an unacceptable price.

DR. GORDON: Thank you.

Shula Edelkind.

MS. EDELKIND: Thank you. I am sure you are all aware of the fact that the Federation of State Medical Boards, which controls medical doctors, M.D.'s, calls all the CAM treatments questionable, and would like to rid the country of all of them whether in the hands of doctors or anybody else. Certainly, this can be seen on the internet on their own web sites.

Doctors who read the scientific literature and use it to help their patients do so at the risk of their medicine licenses. They are the heroes and sometimes the martyrs, as we just heard, of medicine today.

We could create a separate medical board for alternative medicine, but many doctors use both allopathic and alternative treatments. What board would police them? Who would define which camp a new treatment belongs to?

We could add people from the alternative or the CAM community to existing medical boards. But people are not the problem - it is the system itself. The medical board system is broken.

Compare it to our criminal justice system. If you can see this, and it is in your handouts, this is the criminal justice system, one of the best in the world in Section 7 of your handout.

Now, look at what we do to our doctors. In this system, the administrative law system, the medical board itself trains the judge. The medical board can be the plaintiff where no victim is needed, conducts the investigation, is the jury, can set and carry out the sentence.

The doctor often must pay the board for his investigation and his prosecution. This so-called "cost recovery" was ruled unconstitutional for teachers

recently, but it continues in practice for doctors.

As Americans, we should be ashamed. An axe murderer has a better chance of a fair trial than a healer with no injured patients. I think we can do better than that.

One. Correct these overlapping responsibilities, all this stuff on this side of your chart. And it all must be public. This sort of thing can only thrive in the dark.

Two. Only allergists should pass judgment on allergists, and only acupuncturists on acupuncturists. A psychiatrist should not decide if an immunologist did his job right, as happened in the Sinaiko case, and a gynecologist should not evaluate a brain surgeon or vice versa.

Three. Change the focus of the board. We do need to protect the public from doctors with substance abuse problems, incompetence or criminal intent. But we must now allow the medical board to be used as a tool to outlaw treatments.

It is not okay to denigrate a treatment by dismissing it or ignoring existing research, by claiming

that none of it is sufficiently valid, significant, supportive, conclusive, acceptable, or all of the other non-quantifiable criteria.

It is not okay to exclude clinical experience or to exclude testimony by misusing the Daubert rule, which they do now.

The Sinaiko case was used to destroy a safe, low-dose allergy treatment used in England for over 30 years, called EPD. It is no longer available. There is no more access in the United States. You can see this in your handout.

As a consumer of medical care, in conclusion, I believe it is worthless to legislate access to anything if we cannot protect the doctors able to provide it. That includes both CAM and any other treatments.

DR. GORDON: Thank you very much.

Christina Walker.

MS. WALKER: Thank you. I come today to talk. I wear like three hats. I am a nurse, I am a student in a CAM program, I guess if you want to call it, it's a Ph.D. program in energy medicine, and I am also a practitioner of CAM, so I wear three hats, and everything

you brought up today in the commission, I am thinking is a blessing because I kind of hit the bumps with each one of these areas that you have talked about today. So, I just want to talk about some holes that I still see in practicing CAM or as a student of CAM.

My Ph.D., they said I am supposed to be an expert in energy medicine. That is what they tell me. I said okay, I am not quite sure what that means. I have 45 credit hours, and still not quite sure how I am going to practice it under my license of nursing.

Through my research, which I have done through self-observation and observation of clients, and in that I mean I had to actually be a consumer of every alternative medicine therapy there is, write a report how did I feel, what did the patient feel, and through that, I came up with two questions.

At what level of the energetic body organism were these therapies affecting? You have said that you are in a paradigm right now, and we are. CAM therapies work on the physical body, but they also work on the energetic body, so there is two bodies involved in CAM therapies.

So, I ask myself, okay, so when I get an acupuncture treatment, what level is being treated? When I take homeopathy, what level of my energetic organism is being treated? When I get hands-on healing, what level of my organism is being treated? No one was able to answer that question for me, and through my research I did end up with a woman, Christine Schenk, in Europe, who was also on that harmonizing board that the attorney had spoken about.

The next questions I came up with were what are the side effects and adverse reactions of these therapies, and how do they manifest in the physical body, because I also got very sick.

So, some of the side effects of CAM therapy that Christine Schenk has noticed in Europe after 20 years of them doing the work there, is sleeping disorders, constant fatigue, backache, constipation, dizzy spells, hot flushes, chills, circulatory problems, depression, changes in eating habits, and lack of concentration.

So, then what happens is the patient ends up at the physician, and they have got all these complaints,

and he is on the first line of duty to find out what is wrong with the patient, not knowing, because the patients don't tell their physicians either, that they have had CAM therapies.

At the level of the organism of CAM therapy, if we look at hands-on healing, that is considered surgery in the energy body, and that is very, very heavy work, and I am a little concerned when Reiki practitioners, who have taken a weekend course, can hang out a shingle and start working on my chakras and manipulating my energy system when it is surgery. That is what happens in the organism.

In the disks, with rotation, they hold the consciousness of the energy body organism, and in that, if a patient goes to a consciousness, let-me-lift-my consciousness type of week on seminar, they come out with changes in behavior, and they end with the psychotherapist, and he is not quite sure what to do.

The last is the layers, and homeopathy would affect different layers of the organism, so when you give homeopathy to the patient, what level of the organism energetically are you affecting there?

DR. GORDON: Thank you.

Chi Chow.

DR. CHI CHOW: I am Chi Chow, a licensed acupuncturist practicing in New York. I am the founder and current president of the New York Institute of Chinese Medicine located in Mineola, New York.

I am also a former commissioner of what is now ACAOM, the Accreditation Commission for Acupuncture and Oriental Medicine, and a former board member of the Illinois State Acupuncture Association.

I was originally trained as a Western M.D. in China, and have practiced and taught both Western and Chinese Medicine for more than 30 years.

As someone who has an extensive background in both Western and Chinese Medicine, and who has been involved in training practitioners of both disciplines, I would like to emphasize to you that, while complementary in many ways, Western and Eastern medicine practice are very different in approach.

While it is true that a Western M.D. would not require too much time to point a location of the acupuncture point, or to insert the needle in the proper

way, but a much deeper level of understanding is required to perform a proper diagnosis and to outline a proper treatment plan according to Chinese traditional medicine theory.

Without this deeper grounding in TCM, the more superficial knowledge of needling and of the herbs is at best ineffective and at worst can be dangerous to the public. I only have to cite the recent highly-publicized case of a European M.D. inadequately trained in Chinese herbology causing harm to his patient by give the herbs in quantities that would never have been sanctioned by a qualified Chinese herbalist.

The standards of training in our profession in the U.S. are made by ACAOM, the Accreditation Commission for Acupuncture and Oriental Medicine, which is the only national accrediting agency recognized by the U.S. Department of Education for the approval of programs preparing acupuncture and Oriental Medicine practitioners.

The amount of training that is required to become a competent entry-level practitioner of acupuncture or Oriental Medicine has been exhaustively

studied and has been set by ACAOM at a minimum of 1725 hours, or about three academic years, for acupuncture and at a minimum of 2175 hours, or about four academic years, for Oriental Medicine. So, this is actually is pretty comfortable for us to have the training.

We have 43 schools have accreditation. Also, we have a council of Chinese Medicine and acupuncture for the school training, and also have the NCCA to do the certificate, and also have the ACAOM. Those organizations in national cooperate very good for the training of acupuncture and Oriental Medicine student. We feel very comfortable.

DR. GORDON: I am afraid I am going to have to call time. Is there a final sentence or two?

DR. CHI CHOW: Like my point is this setup is very comfortable for training the acupuncture, but for M.D. and chiropractor, only have 300 hours. That really is not enough, and it didn't have any fundamental idea. Acupuncture is not only to give a needle to a point. They have the underlying theory. If you don't have the theory, you don't diagnose. That is nothing.

DR. GORDON: Thank you.

Questions? Tom.

MR. CHAPPELL: If I understand the acupuncture requirements of 200 or 300 hours by an M.D., that is for the knowledge, not for the practice? The practice still requires 1,500 hours?

DR. CHI CHOW: I think there is a difference from certificate license and acupuncture license. M.D., they only get the certificate, but they can practice, and also they can get reimbursed from the insurance.

The licensed acupuncture we have 1,000 hours training. Most of the insurance, they don't pay.

MR. CHAPPELL: I need clarification on this point. My understanding is that an M.D. cannot practice acupuncture on 200 hours of training.

DR. CHI CHOW: No, they can.

MR. CHAPPELL: You are saying they can?

DR. CHI CHOW: They can. Also, the insurance pay them.

MR. MOLONY: It depends. Legally, they can. I think that is the difference that she is talking about. I think when she is talking about they can't, I think it means that there really isn't the competency there to do

a proper diagnosis and treatment at 200 hours.

The 1,500 hours was the World Health Organization developed two different levels for physicians. I think the 200 hours was a general basic knowledge of acupuncture, which might be enough for referral or something of that nature, and then the 1,500 hours would have been for a general practitioner being able to see any patient that comes off the street, and do a credible job with acupuncture.

MR. CHAPPELL: The Commission needs to understand that only 200 hours is required for the M.D. to practice acupuncture.

MR. MOLONY: That is what has been accepted by most state legislatures at this point if only because there has been -- I mean it hasn't been accepted because there is anything other than a 200-hour program that they have all taken.

It hasn't been because the educational criteria has gone through that said that where there is like when you have acupuncturists getting credible educational standards with an accreditation commission and taking the certification examination, and, you know, there isn't a

general proof of competency there for that.

It is assumed because of the way the medical boards work, and their licensure statutes read that they can do anything anyway, so what does it matter, we will just give it to them at 200 hours it seems to be.

MR. CHAPPELL: Thank you.

DR. GORDON: One thing, I think that even though he testified earlier, it might be useful for the Commissioners, with your permission, if we heard Dr. Helms also respond for a moment since he is still here.

Is that all right with everyone because this is one of those issues that we are going to require more deliberation about, but since Joe Helms is here, we might hear a couple words from him.

So, Joe, do you want to come and pull up a chair at the table?

DR. HELMS: First of all, David Molony misrepresents what the WHO document shows. We were both at the meeting. You weren't in the committee as it was being developed, but we were at the same meeting when the standards were being established and voted on.

There are two levels of physician training

recommendations in acupuncture in the WHO guidelines. The first is 200 hours that I discussed in my presentation yesterday. That has been internationally agreed upon as the minimum expected standards for exposure to history, philosophy, point location, needling technique, diagnosis, and applications for integration of acupuncture into medical practice.

That has been uniformly accepted in the states, in Europe, in the Pacific Rim countries, in all countries where Western medicine is practiced.

The 1,500-hour program that was an addendum to the meeting came as a consequence of a specific request that there be a specific denomination in the WHO guideline for physicians who wish to follow the complete traditional Chinese Medicine training equivalent to that of a non-physician trainee.

So, it is simply a physician who elects to do the complete TCM training. That would include full TCM diagnostic capabilities and herbal diagnosis and therapy. So, we are actually not talking about a two-standard for physicians, we are talking about physicians who wish to have the full training of the TCM.

DR. GORDON: Thank you. Other questions or follow up, any of the panelists?

MR. MOLONY: I wanted to thank Joe for that clarification.

DR. CHOW: Being that you are back on the panel here, what is the diagnosis that you use then to work with acupuncture?

DR. HELMS: This might be a distinction that is worth presenting at this point. The distinction that I tried to make yesterday, but apparently didn't make clearly enough, between what we are calling medical acupuncture and what is called traditional Chinese Medicine, which as you and I know is no more traditional than 1959 in Maoist China. It was assembled at that point by a team of primarily herbalist physicians as opposed to acupuncture physicians.

It is a combination of herbal medicine and acupuncture with a herbal diagnostic base. So, when one studies TCM, one studies a diagnostic context that is founded on the desire to prescribe a herbal product as the primary treatment and to use the acupuncture points to reinforce the herbal product.

Hence, the diagnostic paradigm is quite specific to that concept, and it is a very effective concept, it is a very effective approach particularly for chronic internal medicine problems.

In contrast to the TCM herbal model, there is an acupuncture energetic model that is based on the energy flow through the acupuncture channels. Each channel is associated with an organ, the organs combine in specific ways. The organs have responsibilities above and beyond what we consider the responsibilities in physiology. The symptoms and signs that the patients present make sense in the context of the expanded sphere of influence of the organs, which comes from the tradition of acupuncture, and is not unique to TCM, but comes from the long tradition of acupuncture.

That thus provides a physician with an expanded context of comprehending the patient's symptomatology. Understanding the organ system with which a problem is related allows the acupuncturist then to create an energetic input to assist in its modification.

Diagnosis includes all Western appropriate diagnosis, as well as pulse diagnosis, tongue inspection,

palpation of points, palpation of body heaters, as is taught in the tradition of acupuncture, not unique to TCM.

This model of using the expanded body of knowledge based on the syndromes of the organs, based on the functions of the organs from the tradition of acupuncture is easily absorbed into a physician's consciousness, who already is thinking of the physiology and pathophysiology of the organ. It simply adds this information in to expand his comprehension of the patient's presentation, link it with the appropriate acupuncture channel and dynamic, understanding where the points are, and how to move the energy through the certain systems.

This is an approach to acupuncture that can be well taught and well comprehended, well appreciated, and well applied with a strong 200-hour program, and this has been agreed nationally, statewide, and internationally.

DR. GORDON: Thank you. Other questions?

DR. CHOW: May I?

DR. GORDON: Sure, go ahead.

DR. CHOW: I am not quite sure, and maybe this

isn't the time to explain it, but when you talk about an herbal diagnosis, how is that different from a regular diagnosis?

DR. HELMS: The context of herbal diagnosis is the eight principles diagnosis. That is not the primary approach for medical acupuncture, but it is the primary approach of organizing symptomatology and signs in TCM. That is a model, while it is acknowledged, is not the primary diagnostic model of medical acupuncture.

DR. CHOW: I would like to hear, being that we have the opportunity here, I would like to hear more from David and Chi Chow. Would you please elaborate on the concepts that you people expressed?

DR. CHI CHOW: I think TCM, the theory both herb and the acupuncture, they share the fundamental. It is not just only for the herb medicine, no, but the same thing. Acupuncture also used the diagnosis, same eight principles, and the treatment principle, all those with the herb, same thing. The TCM, fundamental.

I think if you want to be a success and treat acupuncture, you have to have the same fundamental of TCM, and then you can make a proper diagnosis, a proper

treatment.

DR. HELMS: If you are working in an herbal context, whether you are using needles or herbs, the eight principles diagnosis applies to that model of therapy. There are other models of diagnosis and organizing treatments that do not require that level of comprehension, because when herbs are not being used in the treatment, it is not necessary to think through the problem in that context.

That is the distinction that I am making. Yes, they share a common foundation, but TCM, as derived from Communist China in the fifties and sixties, is primarily a herbal approach to therapy with acupuncture to support it. It is not a criticism of the quality of acupuncture or the quality of the medicine, but it is quite a different approach from the energy moving through the channels that is linked to medical acupuncture.

DR. GORDON: David, you can respond briefly, but I really think that this is a very deep discussion, and I want to give other people a chance to ask questions of other panelists, as well.

So, David, if you had a brief response, that

would be fine.

MR. MOLONY: It is just that I don't see how 200 hours or even 300 hours could provide more than an extremely basic information on what is necessary to do acupuncture diagnosis and treatment processes. It is less than a semester of class.

It has been part of what is, and I think that over a period of time, hopefully, that there will become more discussion on this subject, and we will all start to work towards having an integrated field of use of acupuncture within our fields, as I actually talked about in my presentation.

DR. CHOW: I just want to sort of complete this in that not only acupuncture, but I think in other practices of CAM, and that was what we brought up before, about the adequacy of other professions taking the training, and this merits an ongoing dialogue on this.

DR. GORDON: I think this is going to be an ongoing discussion, and clearly, there are differences of opinion and also different standards that have applied in different jurisdictions.

Joe.

DR. FINS: I think it is instructive. We have distinguished panelists here who are all experts in acupuncture, and they don't necessarily agree on the standards or the extent of the curriculum.

So, one of the problems I think is that the premise that we have used, especially for Group 4, you know, for CAM practitioners, would be that professional body, that society, we would turn to them to regulate themselves and help them develop standards.

Without a consensus of what the standard is, that delegation doesn't seem feasible, so I think it is just something that we have to take under advisement.

DR. GORDON: Tom.

MR. CHAPPELL: We also say in Group 4 that communities need to be dialogical and that the entity that we are talking about creating is an office here really needs to be facilitated in bringing about some agreement or some common ground on that.

DR. FINS: I think we need a consensus and compromise, and I think as the field has matured, there is a need for people to work together and understand what the motivations are for the different -- maybe it is

going to be 350 hours, and, you know, we will all be happy with that. I don't know the answer to that, and I don't mean to minimize the eloquence of all of your positions, but I think that there is going to be a need for some sort or standardization if this thing is going to mature.

DR. HELMS: Only one reply to that is that the approach to acupuncture and the application of acupuncture from someone who is practicing acupuncture as an exclusive TCM practitioner, and a physician who is incorporating acupuncture into his practice, is quite different. The educational entry requirements are quite different, the education process is quite different, and the application is quite different.

The regulation is different, and one body should not necessarily have influence over the other body as long as each body is self-regulatory for the quality of the training, the verification of the credentials, and the public safety involved in its performance.

MR. CHAPPELL: Let's assume that that is the way it is, that there is sufficient difference in educational philosophy and approach, then, we need to

have sufficiently differentiated names of practice.

DR. HELMS: Hence, we use the name TCM for those who are fully qualified in Chinese Medicine, and medical acupuncture for physicians who are using just the acupuncture component.

MR. CHAPPELL: For the sake of the consumer, then, we simply need to be cognizant of whether or not that is a sufficient differentiation or whether promotion of the full difference as an educational matter can be brought forward.

DR. HELMS: It has served well for 20 years.

DR. GORDON: David.

MR. MOLONY: Perhaps the question is not necessarily whether one aspect of acupuncture can be taught in that period of time, but it may be that what happens, as when almost anybody comes out of knowing one particular aspect of something, pretty soon they read about other things, and they think that they can work with all of them, say that, you know, I am not a five elements practitioner, but say that somebody came out of your course and wanted to do five elements, would read up on it rather than actually study or focus on it.

That is where we have to work together to start to develop criteria and standards to make it so that everybody is on the same page when they are talking with the public.

DR. HELMS: In reality, that doesn't happen. There are plenty of continuing education programs available for physicians in the subdivisions of acupuncture, whether it is five elements, whether it is herbal prescribing, following the full TCM model, whether it is any of the microsystems that are involved.

There are ample continuing education programs that are well attended.

DR. GORDON: Joe, and then I would like to make a point, and then I would like to ask a question about Dr. Sinaiko. So, go ahead.

DR. FINS: I think this argument -- or I shouldn't say argument -- this discussion, the details are important, but the details are less important than the sociologic phenomenon that we are seeing here, and I think it has been really valuable to hear the different perspectives.

It may be delineation of who is doing what. I

agree with Tom, for consumer protection people have to know what they are actually getting, because I am sure the consumers are not going to distinguish between the various entities that they are subscribing to, but I think that as groups come together and things become mainstream, it is really important to foster a mechanism of dialogue, whatever it is.

I think that maybe one of the major recommendations, that we can help foster this dialogue in a collegial way, so we have more than six minutes to figure it out, and to adjust as the field emerges and changes.

I think it has been very, very informative and I personally thank you for your candor in sharing your various perspectives.

MR. MOLONY: I would like to propose that we start talking formally with each other at this point.

DR. CHOW: I think that is a great suggestion.

DR. GORDON: I want to add one other principle that I think may be important. This is confessional. I am licensed to practice medicine and surgery. Now, there are certainly some surgeries I might do, like an incision

and drainage. I am unlikely to want to do abdominal surgery, and I am highly likely if I suspect an acute abdomen to refer the patient somewhere else.

So, I think one of the principles that we have to begin to invoke is a certain sort of befitting modesty about what all of us can and can't do. Aside from discussion and collaboration and dialogue, I think that is a kind of internal process.

I don't know exactly how we put that in our recommendations, but I think that part of the spirit of this work is knowing what we can do for all of us, and what we can't do, and whatever we can do to facilitate that --

DR. HELMS: Educate personal ethics.

DR. GORDON: Whatever we can do to facilitate that process or encourage people to say, and I feel like that is beginning to happen, encourage the different CAM practitioners and conventional practitioners rather than being draconian and saying, well, you have to have this in order to do that.

We want to encourage a sense of appropriateness to the training of what people are doing. So, I just

bring that out.

I do want to thank you all, and thank all on this panel, and also thank you, Joe, for staying around and contributing.

I did want to ask a question about Dr. Sinaiko, because we have heard about him in now I think in five different locations, so I have a personal feeling for him.

What is happening at this point, number one, and number two, I may not have heard completely clearly, what would you recommend that we suggest to state medical boards? We had Dr. Winn here. Did you hear his testimony earlier, who was executive vice president of the Federation of State Medical Boards.

He said that they were busy creating new standards and including distinguished CAM practitioners and scholars in the creation of standards for physicians across the board, in medical boards.

So, I would like to know two things. One is where is Dr. Sinaiko now, how is he doing, and also do you have specific suggestions that you can give us and/or give to the Federation of State Medical Boards?

MS. EDELKIND: To start with, Dr. Sinaiko, the appeal process is going to be beginning sometime in the near future, and we will be involved in that, and probably this time next year we will be able to, if there is another meeting like this, we will be able to update you on that.

At this time, the Union of American Physicians and Dentists, the American Association of Physicians and Surgeons, the California Medical Association, and the Citizens for Health Freedom are all negotiating how they are going to work together and also I believe the Townsend letter, the staff is very interested. So, there are a lot of people that are finding their way in how they are going to be working and cooperating with us.

This has pretty much become one of the biggest medical board cases in California history, and one of the very few medical cases where all of these organizations have shown this type of interest.

As far as the prosecution of the case itself, the prosecutors broke every rule of ethics we could find, and that is going to also be dealt with sometime in the near future, probably at the state bar level.

But as far as the medical board, in California, and, of course, I am not familiar with the rest of the country, but California arrogates to itself the idea that whatever they do, the rest of the country is going to follow, you know, as California goes, so goes the rest of the country. I come from Georgia, so I can say that.

But in any case, yes, they have a new Committee on Alternative Medicine, and originally, this grew out of a Medical Right to Practice Act that was desperately fought for and very widely supported, and totally gutted before it was passed. That was S.B. 2100.

By the time it was passed, instead of being a Medical Right to Practice Act, which would have allowed doctors who practiced various kinds of CAM to practice it, it became a let's study this for three years bill, and in the meantime, don't you dare.

Now, that is really what it is and where it stands right now. There is a committee theoretically in California, and they have had a couple of meetings. I think there are four people, Colleen might know better than me, that are actually on this committee, and on the first meeting, only three of them even bothered to come.

None of them have any CAM experience whatsoever, and on the very first meeting they talked about how all doctors that practice chelation need to be stopped and what their disciplinary procedures for doctors and non-doctors practicing CAM -- well, I guess they are more interested in doctors practicing CAM -- what their discipline should be.

So, this is apparently in California, not so much a committee that is bringing in the idea of alternative medicine into the community of doctors, but rather let's see how we are going to punish them, how we are going to find them, how we are going to weed them out, and get rid of them.

There is also a feeling, you know, if you are not a doctor, we can get rid of you that way, too, because you are practicing medicine without a license. If you have looked on the Federation of State Medical Boards web site, the definition of practicing medicine is so broad that I think that if you put a band-aid on your child, you are practicing medicine. So, it is really pretty scary.

DR. GORDON: So, what would be very helpful to

us is if you could provide us with some of these facts that you are just describing now about what steps are or are not being taken, and who the participants are, because we have an ongoing dialogue with the Federation of State Medical Boards, and I would like to bring this up with them.

The other issue is any specific recommendations that you may have for the functioning of state medical boards in this area, for the review of cases that come to them.

MS. SMETHERS: I would just like to add one comment. Shula and I have been involved in this case since 1997, simply because we were so outraged at what was happening with Dr. Sinaiko, and the reason that was, because we know the kind of a physician he is. I am a clinician, or was a clinician before I retired myself, and I had worked with him in clinics to some degree, knew of him on a lot of other levels, how he practiced and how he cared for his patients, and we became very outraged that this could happen to somebody of his caliber.

Up until then, you always don't really know for sure what the truth is. So, since we have been involved

in this, he has become the poster boy for a whole population of physicians that the same kind of thing has happened to, and we have become aware of them simply because we have been involved in this case.

What is happening in California I understand we are not just the only place that this is happening, but it seems to be a hallmark of states that these kinds of things are happening, and it is a real threat to people who need the broader spectrum of care, not just the allopathic standard of care, in order to deal with their health care problems.

I feel for the patients because they are the ones that are being short-changed, as well as the physicians. They have nowhere to go.

DR. GORDON: Thank you for sharing that with us. We would welcome other examples of physicians or others in other states who are going through this kind of process. That would be very helpful for us.

MS. SMETHERS: I would be happy to.

DR. GORDON: Tom, and then Effie.

MR. CHAPPELL: I wanted to thank Kathleen Quain for bringing the perspective of the quality of the

environment as linked to our health. It is very helpful to be reminded of that.

DR. CHOW: Actually, that was a comment I wanted to make, too, because my feeling was that environment wasn't represented enough in these panels, and so I appreciate that.

One last request. David, can you provide us with that World Health document which states about the number of hours for physicians, and so forth?

MR. MOLONY: I will make sure you get a number of copies of it. I want to state that the Education Committee of the World Health Organization meeting that Joe alluded to earlier, the committee came out with 700 hours, and then by the time it got to the larger committee, it was back down to 200 hours, which happens to be the length of his course.

DR. GORDON: I want to thank all of you for coming. I want to thank also the Commissioners who are here at the end. That's great, I really appreciate the energy and enthusiasm.

[Applause.]

DR. GORDON: And also our staff, who have been

here before, during, and after.

[Applause.]

DR. GORDON: Those who are here, those who are there, and those who are still outside, working outside. So, thank you, everybody. We look forward to seeing you again, and please be in touch with us.

[Whereupon, at 6:30 p.m., the meeting adjourned.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE: White House Commission on Complementary and Alternative Medicine Policy

HELD: February 22-23, 2001

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

DEBORAH TALLMAN, Court Reporter