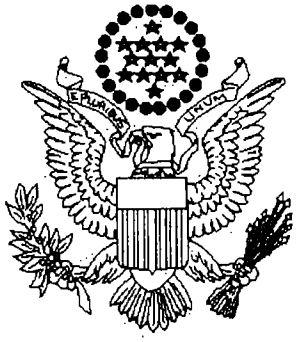

White House Commission on Complementary and Alternative Medicine Policy

Town Hall Meeting
Hubert H. Humphrey Institute
Minneapolis, Minnesota

March 16, 2001
8:00 a.m. – 6:00 p.m.

Commissioner's Briefing Book

Background Reading on Minnesota Legislation "The Complementary and Alternative Healthcare Freedom of Access Act"

Contents:

White House Commission on Complementary and Alternative Medicine Policy

Town Hall Meeting: March 16, 2001
Hubert H. Humphrey Institute, Cowles Auditorium
Minneapolis, Minnesota
8:00 a.m. – 5:30 p.m.* (6:00 p.m)

Final Agenda

8:00 a.m. – 8:15 a.m. Opening Remarks and Introductions

Michele M. Chang, CMT, MPH
Executive Secretary, White House Commission on Complementary and Alternative Medicine Policy

The Honorable James S. Gordon, MD
Chair, White House Commission on Complementary and Alternative Medicine Policy

- Commissioner George DeVries
- Commissioner Wayne Jonas
- Commissioner Linnea Larson
- Commissioner Joseph Pizzorno

Welcoming Remarks

Gayle Hallin, MPH, BS
Assistant Commissioner, Minnesota Department of Health

8:15 a.m. – 8:55 a.m. Access, Financing and Reimbursement

1. Frank Cerra, MD, Senior Vice President: Academic Health Center, University of Minnesota (U of M)
2. Chris Foley, MD, Dir of Integrative Health: HealthEast Care System, Woodwinds Clinic
3. Roger Chizek: Medtronic
4. James Woodburn, MD, MS, Medical Director: Blue Cross/Blue Shield of Minnesota
5. Patricia Culliton, MA LAc, Director: Alternative Medicine Clinic, Hennepin County Medical Center
6. Lynn Lammer, BA, JD: Homeopathic Consultants, Inc

8:55 a.m.– 9:35 a.m. Integration of CAM into Care Delivery Systems

7. Sharon Norling, MD, Medical Director: Mind Body Spirit Clinic, Fairview Health Systems
8. Julie Schmidt, CEO: Woodwinds Health Campus
9. Tim Culbert, MD, Medical Director, Integrative Therapies: Children's Hospitals and Clinics
10. Carolyn Torkelson, MD: Bush Fellowship Program of Study
11. Kathy Schurdevin, President: MN Natural Health Legal Reform Project

* An additional 30 minutes has been added to the program to accommodate an overflow of speakers beyond the time originally allotted. Written comments from speakers who could not be fit into this expanded agenda may be submitted on-site or through our website: http://whccamp.hhs.gov

9:35 a.m. – 10:15 a.m. Dietary Supplements

12. Matt Wood, Cofounder: MN Natural Health Coalition
13. Jodi Chaffin, PharmD, Chair: Herbal Taskforce of MN Pharmaceutical Association, Healthpartners
14. Rick Kingston, PharmD: PROSAR International Poison Center
15. John Mastel, Nutritional Consultant and owner: Natural Foods Store
16. R. William Soller, PhD, Vice President and Director of Science and Technology: Consumer Health Care Products Association

10:15 a.m. – 10:55 a.m. Education of CAM Providers

17. Margery Wells, Dipl, Oriental Medicine: American Association of Oriental Medicine
18. (Val Ohanian, RS, Hom (NA), Assistant Dean) Northwestern Academy of Homeopathy
19. Jackson Petersburg, Director: Center Point
20. Barbara York, President: MN Touch Movement Network
21. Rose Haywood, Academic Dean: MN College of Acupuncture and Oriental Medicine of Northwestern Health Sciences University
22. ~~Michael Green, MD~~

10:55 a.m. – 11:10 a.m. BREAK

11:10 a.m. – 11:50 a.m. Education of Health Professionals

23. Mary Jo Kreitzer, PhD, Director: Center for Spirituality and Healing
24. Bill Manahan, MD, Assistant Professor, Department of Family Practice: U of M
25. Erin O'Fallon, BA, (MD in May 2001): U of MN Medical School
26. Patricia Cole, MD, Director of Family Practice Residency: Hennepin County Medical Center
27. Mary Johnson, PhD, RN, Department of Nursing: St. Olaf College
28. Janet Dahlem, MA, Director: Holistic Health Studies Program, College of St. Catherine

11:50 a.m. – 12:30 p.m. Research

29. Robert Patterson, PhD, Professor, Physical Medicine and Rehabilitation: U of M
30. Janice Post-White, RN, PhD, FAAN, Associate Professor, School of Nursing: U of M
31. Chris Hafner, BA, Dipl Ac LAc: Cloud River Traditional Chinese Medicine
32. Mary Ellen Kinney, RN, Coordinator of Complementary Therapies Research: United Hospital (Allina)
33. Milton Seifert, MD: Eagle Medical
34. Frank Dennis Wiewel: People Against Cancer

12:30 p.m. – 1:30 p.m. LUNCH BREAK

1:30 p.m. – 2:10 p.m. Culturally-based Healing Traditions

35. Okokon Udo, Director: Center for Cross-Cultural Health
36. Michele Strachan, MD: Powderhorn Wellness Center
37. Thupten Dadak: Tibetan American Foundation of Minnesota
38. Master Chunyi Lin, Founder: Spring Forest QiGong, Inc.
39. Jose Reyes: Itzamatul Itolixtli Danzantes
40. Sabina Pello: American Association of Immigrants from the former USSR (IL Branch)

2:10 p.m. – 2:50 p.m. Regulation

41. Tom Hiendlmayr, Director, Health Occupations Program: MN Department of Health
42. Michael Myers, JD, Chair of Health Services Administration: University of South Dakota

Regulation (Continued)

43. Michael Morris Kleiner, PhD, Professor: Hubert H. Humphrey Institute of Public Affairs: U of M
44. Rob Leach, Executive Director: Board of Medical Practice
45. Marillyn Beyer RN, BSN, MA, President: MN Natural Health Coalition
46. Rebecca Frost, RMT,CMT, International Somatic Movement Education & Therapy Association

2:50 p.m. – 3:30 p.m. Minnesota Legislation

47. Diane Miller, JD, National Health Freedom Coalition
48. Representative Lynda Boudreau: MN House of Representatives
49. Shirley Brekken, Executive Director: MN Board of Nursing
50. Stephen Bolles, DC, VF :Northwestern Health Sciences University
51. Helen Healy, ND: Wellspring Naturopathic Clinic
52. Jerri Johnson, BS in Nursing: MN Natural Health Coalition

3:30 p.m. – 3:45 p.m. BREAK

3:45 p.m. – 4:20 p.m. XI Open Sessions

53. Susan Hageness, MA, RN: Children's Hospitals and Clinics
54. Pamela Ahrens, MA, Library Science: Children's Hospitals and Clinics
55. Bob Barron, RN, ADN: Wellness Educators
56. Kate Birch, AS, RS Hom(NA), CCH, CMT: Minnesota Homeopathic Association
57. Ann Richtman, JD: Northland Natural Health Resources, Inc.
58. Tenby Owens, Master of Pulse Diagnosis: St. Luke's Center for Holistic HealthCare

(15 min)

4:20 p.m. – 4:55 p.m. XII Open Sessions (continued)

59. Howard Fidler, DC: American Chiropractic Association
60. John Toft DC: Functional Medicine Chiropractic Center
61. Marilynn Anderson: The Feldenkrais Guild of North America
62. Chu Yongyuan Wu, MA: Hmong Shaman Research Project
63. Jeffery Dusek, PhD: Mind/Body Medical Institute
64. Richard Pavek: The SHEN Therapy Institute

(15 min)

4:55 p.m. – 5:25 p.m. XIII Open Sessions (continued)

65. Larry Caldwell, MS (Oriental Medicine): Acupuncture Association of Minnesota
66. Zhaoping Li, MB (China), LAc (MN): MN College of Acupuncture and Oriental Medicine
67. Changzhen, Gong, PhD, MS: American Academy of Acupuncture
68. Jennifer Blair, Diploma in Oriental Medicine: Acupuncture Association of MN
69. Ike Rodman, PhD: Northwestern Health Sciences University

(15 min)

5:25 p.m. – 6:00 p.m. ~~XIV~~ Open Sessions (continued)

70. Gregory Schmidt, MFA: MN Natural Health Legal Reform Project
71. Leo Cashman, BS, MA, DAMS, Inc: MN Natural Health Legal Reform Project
72. ~~Amrit Devgun, N~~D: Santulan Health Center Testimony to come later

Allen Anderson

73. Gayle Bowler: Minnesota Natural Health Coalition
74. Jeanne Hollingsworth: MN Natural Health Coalition
75. Nancy Hone, BA Nursing and MAT: MN Natural Health Coalition

(15 min)

6:00 p.m.* ADJOURNED

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8:15 – 8:55 a.m. I. Access, Financing and Reimbursement

1. Frank Bernard Cerra, MD
University of Minnesota
making data into information - challenge (informed consumer)

(2.) Chris Foley, MD — Lodc to this testimony - Reimbursement models cited (Medtronic)
Dir of Integrative Health
Clin Asst Prof Univ of Mn Coll of Pharmacy , Ed J Am Nutraceutical Assoc, former pres Minnesota Chapter Am Soc of Int Medicine, HealthEast PRE-TAX MEDICAL ACCOUNTS

NOTES:
Will speak to the manner in which current the payment system inhibits legitimate patient choices involving integrative approaches to healthcare.

(3.) Roger Chizek: Medtronic – look into reimbursement model: more consumer autonomy

4. James Woody Woodburn, MD, MS, FACEP
Blue Cross Blue Shield of MN

5. Patricia Culliton, MA LAc, Director
Alternative Medicine Clinic, Hennepin County Medical Center
(check) lobbyists already tax to HCFA for reimbursement

6. Lynn M Lammer B.A., J.D.
Homeopathic Consultants, Inc

NOTES:
Ways to improve access to CAM and what types of CAM practices/interventions should be reimbursable through coverage systems.

(20 min)

8:55 – 9:35 a.m. II Integration of CAM into Care Delivery Systems

7. Sharon Norling, MD
Medical Director, Mind Body Spirit Clinic, Fairview Health Systems

8. Julie Schmidt, CEO missing testimony
Woodwinds Health Campus

9. Timothy P. Culbert, MD
Children's Hospitals and Clinics Children's Health STATS on CAM use on Task Force (AAP)

NOTES:
Uniform standards for specific CAM practitioners are being created within Children's Hopsitals and Clinics organization through credentialing and privileging procedures. In addition, western (allopathic) trained nurses, psychologists, and physicians who wish to practice CAM therapies in an integrative fashion will also have the option of a specialty credential in our system that designates them as an "integrative" practitioner.

10. Carolyn Joyce Torkelson, MD
Bush Fellowship Program of Study

TESTIMONY:
I am a conventionally trained FP physician practicing holistic medicine, incorporating natural approaches to health care. My background includes:

-- Former medical director for the office of Complementary medicine at PNC a large health system in MPLS.
-- From 95-98, proposals for a CAM center were considered but denied secondary to administrative and financial barriers. Foundation money was denied and has recently been denied for research in healing touch.
-- Currently on a Bush Fellowship, studying Integrative centers throughout the US.
-- Private grant-making foundation designed to provide physicians with the opportunity to take LOA from their practice to pursue professional development that addresses the health care needs of the community.
-- Board certified in Holistic Medicine
-- First holistic board certification offered Dec 7, 2000

As a clinician, prepared to deliver CAM services and integrative care, I am faced with the reality that there are few clinical settings in which to practice. If we believe our current health care system needs to incorporate integrative medicine then broad application of CAM needs to be made available.

While it is important to educate medical students and continue quality research in CAM, we also need to provide clinical settings where the consumer has easy access to our skills, knowledge, and leadership. What is necessary for CAM to become mainstream is the successful demonstration of medical and fiscal outcomes. This demonstrated success will help overcome the significant barriers to integration from our conventional colleagues.

In my Bush fellowship, I have had the opportunity to study various clinical models that exist in the U.S. all with varying degrees of success. These can be classified into four general models of clinical application:

-- CORIDOR model where practitioners of different healing modalities are housed in the same building.
-- PHYSICIAN DIRECTED model where an independent practitioner provides CAM care.
-- PROBLEM DIRECTED model where clinics are created to treat a specific disease.
-- CENTER-ORIENTED model where a site is dedicated to provide CAM practitioners who work collaboratively with one another.

My proposal is to create a different model that I believe can be successful. A "Charter Clinic" much like the charter school phenomenon - where a center is dedicated to providing care to a subset of individuals with specific needs uniquely offers:

Clinical:
demonstration project
-- "Integrative care" (a holistic philosophy of care using conventional medicine and CAM modalities in a collaborative interaction of practitioner(s) and client. William Stewart, MD stated that to understand integrative health care one needs to "expand the meaning of health and deepen the understanding of healing).
-- A designated location (versus the "clinic without walls" approach) where integrative clinical skills are applied in a safe and trusted environment.
-- A "laboratory" where students, residents, and physicians interested in CAM can learn and develop skills.
-- Education/Information resources offered to community and colleagues

-- Retailing of nutriceuticals and supplies.
-- Research component to look at outcomes and cost effectiveness
-- Referral network for independent CAM practitioners.

Financial:
-- Fee for service in an independent model outside the health systems.
-- A private sector or major institution (e.g. university, HMO, Insurance Company, etc.) need to be invested by providing funds, space, personnel, marketing and collaboration.

My experience with a large manage care system, Park Nicollet Clinic, was that the barriers were just too great.

-- The organizations are scrambling for survival. New programs are not top priority, especially ones that may be controversial.
-- Strong resistance from a few MDs can cause fear in the minds of others and therefore no change is made.
-- Reimbursement for primary care is poor. Even in acute primary care seeing 20-25 patients a day -it is still a cost center, let alone seeing only 10 patients in an integrated model. Procedures get the best reimbursement from insurance.
-- Government support to dedicate funds, direct policy, and support CAM through improved reimbursement.

Summary:
It is important to understand:
-- Consumers are demanding safe and accessible integrative care.
-- CAM providers are available...300 took the holistic boards in December 2000.
-- A clinical setting for CAM providers are needed to practice and demonstrate the Art and Science of medicine.
-- Charter Clinics is a model that would demonstrate success and built on the future of integration.

11. Kathy Ann Schurdevin BS, RN, Classical Homeopath
President, MN Natural Health Legal Reform Project

(20 min)

9:35 – 10:15 a.m. III Dietary Supplements

12. Matthew Yavner Wood
American Herbalists Guild

NOTES:
I believe I will be on a panel organized by Mary Jo Kreitzer. I have been a CAM provider for 20 years in the field of herbalism, am a professional member of the American Herbalists Guild and a well known author in the field. I wish to address: (1) what I believe is the right of all people to practice and receive traditional folk medical care according to their personal community standards and their personal philosophy and spiritual beliefs; (2) the need for government not to suppress alternative ways of thinking about and using herbs and other CAM therapies; (3) the need for flexibility in regulation so that the use of safe (not toxic) plant medicines is available to the public.

13. Jodi A. Chaffin, RPh
MN Pharmacists Association and HealthPartners

NOTES:
SAFE USE OF DIETARY SUPPLEMENTS: People self-medicating with dietary supplements, are reaching out to their healthcare providers for safety information, in order to avoid adverse

#F.

& Jonas - Culbert

reactions and/or interactions. Safety information, which could be of value, is not available. A post-marketing program designed to gather, review and disseminate safety information, that would be of value, is needed.

14. Richard Leon Kingston, PharmD
UoMN/PROSAR Intl Poison Center

NOTES:
Remarks will include examples of regulatory initiatives that can serve as incentives to patients and health professionals for them to consider CAM options as compared to mainstream medical approaches to health. I will also address the limitation of existing regulations and need for new approaches for dietary supplement postmarket surveillance to insure that health professional students and practitioners will have the necessary confidence in these products to routinely recommend their use.

15. John Mastel
Nutritional Consultant and ownerNatural Foods Store

16. R. William Soller Ph.D.
Consumer Healthcaree Products Association

testimony to Ken for review Fup

NOTES:
FDA has ample authority to ensure that dietary supplements (DSs) are safe and of high quality. Items in FDA's as yet unfunded long-range plan for DSs are the issuing/implementing Good Manufacturing Practices, improvements to FDA's adverse report monitoring, and a report to Congress on how much CFSAN needs to implement its long-range plan. A way to improve the professional access to safe, high quality DSs is the Commission's support for Congressional appropriations for FDA's long-range plan.

10:15 – 10:55 a.m. IV. Education of CAM Providers

17. Margery A. Wells (no testimony?)
Diplomate in Oriental Medicine, American Association of Oriental Medicine, Health Source

Someone willing to help build bridges? (not according to actual testimony)

NOTES:
In our paper, "Integrative Medicine: Merging Traditional Oriental and Western Medical Practices", Dr. Gonzalez-Campoy, M.D., Ph.D. and I define oriental medicine within the context of western medical practices, and also address the potential for creating collaborative research and clinical work.

18. Val Ohanian, RS, Hom (NA) Substituted by Lynn Lammer
Assistant Dean
Northwestern Academy of Homeopathy

19. Jackson Petersburg
Director, Center Point

20. Barbara York
MTMN—Minnesota Touch Movement Network

NOTES:
Under any name of touch service, inclusiveness must incorporate the diversity of styles, training, culture, and community needs that are represented by the consumer. If complementary and alternative health care is to meet the needs of the consumer, a standardized program cannot possibly meet the consumers, let alone the practitioners, needs. The nature of the work of healer is peculiar to the recipient, not the giver. We must guarantee the givers flexibility to meet that need.

21. Rose Haywood, L.Ac., Dipl.Ac.(NCCAOM)
Minn. College of Acupuncture and Oriental Medicine, Northwestern Health Sciences University

NOTES:
The importance of quality education in herbal medicine: Now in the US, the only credible certification of competency in herbal medicine is the Chinese herbology exam of the National Certification Commission for Acupuncture and Oriental Medicine. In European/American herbal medicine in the U.S, there are no nationally recognized standards of education. These standards must be established to ensure safe and effective practice.

~~22. Michael Green, MD~~

NOTES:

Background: MD, Family Practice > 10 yrs, practicing acupuncture for > 2 yrs. #2: Personal experience with patients' problems with insurance coverage for acupuncture. Lack of coverage for Medicare patients & many private insurance plans. #3: Cautions about uniform standards in Oriental medicine training, different assumptions in MD and non-MD training and widely varying "schools" of practice .

10:55 – 11:10 a.m. BREAK

11:10 – 11:50 a.m. Education of Health Professionals

23. Mary Jo Kreitzer PhD, RN
University of Minnesota

24. Bill David Manahan M.D.
Center for Spirituality and Healing

NOTES:
One of the barriers to improving American healthcare is that we have a physician medical monopoly. Competition and making individual choices have helped make America a great nation. Yet in health care, Americans have neither the financial nor informational resources to be able to choose from the wide range of appropriate healing professionals. I will discuss how this can occur. For details, read Not What the Doctor Ordered by Jeff Bauer.

Numbers 3 & 4 listed above are the areas that I will cover, because they both are asking how to educate HCP's about CAM. My speech will discuss details of a 3-week CAM course I have taught to medical students and physicians for 4 years. Much of the course is experiential taking place in the offices of CAM practitioners.

course about critical thinking

TESTIMONY:
The purpose of my talk is to present what I believe is a successful model of how to educate

physicians and physicians-in-training about complementary and alternative medicine. The core idea of the training is to expose students and physicians to the office practices of multiple CAM practitioners so the physicians can experience what is really going on in a world about which they know very little. Here are some typical comments from the medical students and physicians who recently completed this three-week course.

"I can't believe I am done with my practitioner visits. This course was wonderful. I have really been enjoying this elective. I think that I have broadened my mind to the level of confusion, but I trust things will sort themselves out in my psyche. I definitely wish we had 6 weeks instead of 3 to cover such a huge topic. I have seen a lot of cool stuff that I can accept. I have come to a point though that may surprise you. I do not think allopathy and CAM are really all that different at their core essences. It is nice to be with healers other than MDs. I am awed by what is out there. The practitioners we visited have so much training, have good credentials, and they really want to help people optimize their health." (I have two pages of other similar comments from just one group of 8 students)

What expectations do students have after training? Referral?

The reason I believe this course is so powerful is because the primary faculty are the CAM providers in the community. They teach the students as they are taking care of their patients. The students get a chance to talk to their patients and discover from them the strengths and weaknesses of our present medical system. The course also acts as a bridge bringing together CAM providers and physicians or physicians-in-training. The students also act as ambassadors for allopathy bringing to the experience some humility, compassion, and a desire for learning from the CAM practitioners that has frequently been absent in our relationships.

"Pharmaceutical medicine"

The course is primarily for senior medical students but has been taken by residents and practicing physicians. It consists of 30 half-days with 15 of those days being spent in the offices of CAM practitioners doing acupuncture, biofeedback, chelation therapy, chiropractic, energy healing, homeopathy, hypnosis, massage and music therapy, naturopathy, osteopathy, shiatsu, and traditional Chinese medicine. Five half-days are spent with me in the classroom with about half that time used to process what the students are thinking and feeling about their experiences. We have e-mail communication two to three times each week. The other ten half-days are used for research, reading, reflecting and having fun. On the final day of the course, each student presents a 15-minute paper on the topic of his or her choice.

With all due modesty, I believe this course is one of the best ways I have ever experienced to educate physicians about CAM and to educate CAM providers about physicians. I suspect the practice of medicine would quickly change if we had every senior medical student, every primary care resident-in-training, and every primary care physician do a similar three-week course.

25. Erin Colleen O'Fallon BA, (MD in May 2001)
University of Minnesota Medical School

NOTES:
As a senior medical student I have just completed an elective course titled "Intro to Complementary and Alternative Medicine" . I felt this course was extremely valuable complement to my medical school education. Learning more about alternative practices has allowed me to understand allopathic medicine better. I'm more comfortable discussing alternative options of health care with patients. This experience would be valuable to health care professionals in all stages of their training.

26. Patricia Cole, MD
Director of Family Practice Residency, Hennepin County Medical Center

27. Mary Buntrock Johnson PhD, RN no testimony
St. Olaf College

NOTES: how you do what you do not what you do
Information, evidence, legal and ethical issues, and cultural differences concerning CAM practices need to be incorporated into undergraduate nursing curricula. Needs: * assess patient use of CAM, * evaluate the impact of CAM, * document appropriately, * determine safety and efficacy * explore resources * describe ethical and legal issues surrounding CAM use Results of a 5 year survey of nursing student perspectives on holistic nursing will be shared.

28. Janet Dahlem
Director, Holistic Nurses Association, College of St. Catherine

11:50 –12:30 p.m. VI Research

29. Robert Patterson, PhD
Professor, Physical Medicine and Rehabilitation, U of M

30. Janice E. Post-White PhD
University of Minnesota

NOTES:
My testimony will focus on the need for rigorous intervention research that tests the effectiveness of CAM, documents outcomes above and beyond those of "standard care," and advances the science of Integrative Medicine. There are many unique issues to conducting CAM intervention research, which requires specific training. Integration of CAM research in community care requires careful consideration to maintain scientifically valid findings relevant to practice.

31. Christopher James Hafner L.Ac.
Cloud River

32. Mary Ellen Kinney RN, BA
United Hospital/Complementary Therapies Research

TESTIMONY:
I am working on a research study entitled The Effects of Therapeutic Massage and Healing Touch on Cancer Patients. I am involved in the study because it was the *only* way I could find to bring complementary therapies into the inpatient setting of the hospital where I work. Through this study, I have gained a great appreciation for the scientific process, and the subjective comments from scores of our research subjects support its value in their lives. In fact, one woman could not wait to tell her story, when, after receiving Healing Touch, she rapped on my door and burst into the office saying, "Look at me. Look at me!! Today is the day in my chemo cycle when I am always admitted (to the hospital)...but that's not what it's about. It's not about the diarrhea or the nausea or the vomiting or the mouth sores. Can you see it? I am *living* for the first time since I was diagnosed. It is my spirit, Mary Ellen-- my spirit. Look at me!" She spread her arms and twirled in front of me. In addition to recognizing and appreciating her obvious vitality, my thought was "What am I witnessing here? And just how do we measure that?" How do we measure the ineffable using the construct of our current scientific methodology?

The goals and philosophy of CAM include wholeness, wellness, and healing. These are inherently expansive concepts that lead to questions of consciousness, interconnectedness, transcendence, healing, spirituality and more. If we ask the questions that CAM prompts, then a methodology that

supports the research to find the answers is required. The current methodology of rigorous science is serving us well in some arenas, but it is based on a reductionist model, and reductionism and wholism do not resonate. We work to fit energy-based mind, body, spirit healing into the randomized controlled double blind trial. I recently heard a person report that an investigator in a Healing Touch study found a way to single blind the subject who was lying supine on the table by hanging a drape just below her chin to prevent her from seeing if she was receiving Healing Touch or not. In an effort to adhere to the scientific model, the subject's head was effectually cut off from the healing.

Looking again at the woman in my office, the results we obtain from the randomized controlled trial may be valid, but they are certainly incomplete. We can measure her episodes of diarrhea and vomiting, the number of antiemetics and pain medications she uses, and measure her endorphin, T cell and cortisol levels. We can measure length of inpatient stay and even quality of life, but if we listen carefully to what she told us, we still will not capture measurement of what she identifies as the underlying key to her experience-her spirit. This calls for advancement to another level of reliability and validity in research methodology.

We are already practicing and benefiting from an integrative medicine and our healing practices are moving beyond what can currently be measured in a reductionist manner. Science must evolve along with medicine to continue answering the questions and assuring safety and efficacy for the people seeking wholeness. I have confidence science will answer the call.

33. Milton Henry Seifert, MD
Eagle Medical

NOTES:
Expand the research environs by making the practice of a lab, using Grounded Theory, Multimethod research (Miller & Crabtree), and The Patient as Colleague. Experience with blending care and research will be described. A Health Status Assess was created using health behaviors and the SF36 of WARE, for measures of physical, mental, social and spiritual health; for education, negotiation, and outcome measures. These plus intentional logic (Wheeler) lead to greater accountability and safety. Informed consent lit (CAM, Trad, Malpract Ins) all rely more on pract/pt relationships than on education, training, certif, or licensure. Thus, bottom-up system change

move to research

34. Okokon Udo — refer to transcript response about developing
Director: Center for Cross-Cultural Health "openness" at the policy level

12:30 – 1:30 p.m. LUNCH BREAK

1:30 – 2:10 p.m. VH Culturally-based Healing Traditions

35. Frank Dennis Wiewel
People Against Cancer

NOTES:
In The year 2001 it is expected that more than 1,500,000 American citizens will be diagnosed with cancer and more than 750,000 will die, notwithstanding the best conventional therapy. It my discussion today I will address how the White House Commission can illuminate and research alternative methods of resolving cancer and the deadly diseases and change the face of American medicine forever.

36. Michele Denize Strachan MD
Powderhorn-Phillips CulturalWellness Center

NOTES:
The health of African-American and recent African immigrant populations in the United States remains an unmet challenge by current health care delivery systems. If the inquiry into, the institutionalization, and regulation of CAM overlooks particular and pertinent cultural determinants and definitions of health including different practices and culturally-specific practitioners, the discrepancy in health status of populations of cultures other than the European can only continue to increase.

TESTIMONY:
In recent weeks, I went home to the place of my birth and upbringing -- the island of Haiti. And my brother, the Chief of National Police in the government of Rene Preval, took me on a tour of a reality unseen and unshowable through the eyes of CNN. We traveled the countryside and he recalled meetings where experts had presented a menu of development options about which the attendees were asked to give their opinions. Those, he contrasted to gatherings where the President and advisors came to listen to the people and simply asked them "What do you think we should do?" And the people said "Build us the roads." "But..," the advisors had protested. And to every question about the complexity of the many facets of development the advisors had raised, the people had maintained "Build us the roads." So the President built the roads--not perfectly, not according to international standards, not according to a technical plan approved through several layers of international scrutiny. The President simply built the roads. And the result is a hum and vibrancy of life being rebuilt in centers away from the capital city; the result is clean public places without a maintenance crew, the result is a people who with quiet pride intone a slogan:"Let them talk, *we* are doing the work!" The people had, in short, said "Build us the roads and health will follow." And in their language, their pride and the vibrancy of their communities away from the mainstream, I saw health.

The people of Haiti are closely linked --genetically, linguistically, spiritually--to the Fon people of West Africa, now mostly living in the country of Benin. I visited there in 1996 and again in 1998 to study with elders and healers dedicated to looking to the ancestral legacy to find indigenous answers to indigenous challenges, such as health. One of them, Dr. Jerome Medegan Fagla, a western trained biochemist and physician as well as spiritual elder trained in the ways of his father and grandfather, has dedicated the greater part of his professional life to finding the key to alleviating the suffering of people with sickle cell anemia. We visited the Center in Cotonou where he receives patients and requests from all over West Africa for the eight plant remedy that reverses the effects of sickling. There, mothers told us that so long as their children --often initially brought to the doctor at the brink of death-- remain on the remedy, they are now leading a normal life, free of pain, full of activity and with normal growth. Dr. Fagla spoke to me of colonialism and the recent interest in complementary medicine in the following words: "First," he said, "they came and with disgust wanted to disinfect us; told us our medicine was worth less than dirt! Now, they come back wanting our plants and with all the dirt on them."

Because the journey of our past is complex and tortuous, the journey to health is also complex.
I have in the course of my journey as a physician seeking relevance and efficiency in working with my people's health and well-being, seen many things: as a primary care pediatrician in the *barrios* of East Harlem and Washington Heights in New York City and the Haitian neighborhoods in Cambridge and Boston; as Assistant Director for Health Care at Save the Children Federation, in my visits to support Child Survival programs in Central and South America, Africa and Southeast Asia, promoting internationally developed strategies of health within small communities who struggled to make them fit their realities and ways of thinking; as the lead Pediatrician in the Pediatric Sickle Cell Clinic at Columbia Presbyterian Medical Center,where the crises of the pain of dislocation and isolation rivaled painful crises of vaso occlusion in intensity and disruption; as a physician in the Indian Health Service, first as Clinical Director of the hospital in Eagle Butte, then as Director of a

Fetal Alcohol Surveillance and Intervention Program throughout the Dakotas, I have long sought and pondered the health of our peoples and the limitations of the profession and modern science in taking us there.

Moreover, in my journey, I have long suffered from the alienation and irrelevance that comes when the white coat of the profession subsumes the authenticity of who I am culturally. The people around the world in communities, struggling with Child Survival constraints, said "But you know this may not be what we need to do." And the reproach in their eyes spoke louder than words. The people of the Sioux nations in the Dakotas said "We cannot see you, or trust you; you represent the Federal government" In fact, the Sioux of Cheyenne River said "You are a white man." and it took me years to fully experience the truth of their assessment. And my people in Boston and New York came for me and seldom for the medicine. When I forgot, they stopped coming.

They often stopped coming anyway in ways that were very confusing to me. Then,five years ago, I began in earnest, the study of what is missing in our communities where health is so elusive. I began that study in much the same way that my brother described when he talked about what is taking place in my home country under the name"the end to exclusion". Guided by the founding team of the Powderhorn Phillips Cultural Wellness Center, I began to develop the listening skills that allowed me to say to people as they gathered, "What do you think we should do?" And the people told us "We need to stop being scared, we need community, we need to remember who we are by reconnecting to our heritage."

I am now the Director of Medicine at the Cultural Wellness Center, where I collect stories as people renew their zeal to forge for themselves a journey to health. The constant and recurrent theme is how do I reconnect? How do I overcome the obstacles, both within myself and within our community, to the reconnection that leads me back to an experience of myself--not confused, not crazy, not in pain. But myself, whole. This is happening in groups of African men exploring health in a collective dedicated to strength in movement, in the Coalition of African Women rebuilding our communities through workshops and potluck dinners, in Guatemalan and Latinos United Efforts through ESL classes, in European American women through rituals, song and art that heal and build community, in the group from Minnesota Resource Center for Indian Women who explore the Joy of Movement. And there are more, all who say: "disconnection from my people is the root cause of disease. Being with people who look like me is essential to my health."

Some of our most challenging work involves classes for health professionals in training: medical students, residents, public health students, nurse practitioner students, and graduate students in Holistic health counseling, whose program directors you will have heard from earlier this morning. Our aim is to sensitize the health professional trainees to the cultural paradigm that defines the western medical system, and underlies CAM as it has become adapted to and incorporated into western medicine. We do this by immersing them into, not only the content of our work at the Cultural Wellness Center but, more importantly, into a cultural way of knowing and learning which often mirrors to them the way modern Western culture, captured in medical science and its practitioners, looks when viewed from the vantage point of a different cultural perspective. Invariably, the most difficult challenge is for students to shift their cultural focus to another lens. The Center staff is often angrily dismissed as "not teaching anything" or of being insulting in this long and delicate process of unsettling people from the invisible cultural container that is held as universal rather than one of many cultural views. We keep teaching; honing our sensitivities and affirmation that the invisible cultural perspective of the training of health professionals is different from and often in conflict with the unspoken cultural perspective of our people as they rebuild their way to health as they define it.

There are many statistics which depict in numerical terms what my people have said in their stories and known in their bones: that we, and our health, exist outside of the mainstream. Whether we care to look at infant mortality, life expectancy, the ascess to diagnostic and therapeutic procedures for coronary heart disease, the prevalence of diabetes, the severity and case mortality of

hypertension, or the screening and case mortality for breast cancer, the health and survival of Blacks lags well below the national average and more dramatically below the health enjoyed by White americans. If this discrepant picture is to change, if the health of Blacks and other indigenous peoples is to flourish, contrary to the pattern of the past two hundred years, this is what I recommend:

1. The building of culturally-specific network systems and communities is an essential health intervention supported not only by the people who need them, but by a wide body of literature. It is time for the system to recognize it as such by paying and reimbursing for it.

2. Cultural elders, shamans, and healers are needed not only for the content of the practices that are best suited to the complex and chronic ills of indigenous people, especially displaced peoples. Cultural healers are essential to the health of indigenous people because they embody the process of reconnecting to and the continuity of a heritage, the erasure of which is at the root of our worsening health status. The body of knowledge of such healers exists outside the cultural domain of western empirical science. The education of such practitioners is through apprenticeship and involves arduous spiritual development which can only be appraised within that spiritual healing tradition. Certification comes from the Circle of Elders who oversees the continued quality of the healer's work by involving the participation of the community.

Because of the complexity of both the disconnection and health status of our people at this time in the United States, it is best to pair the work of cultural elders and healers to that of a licesnsed physician, nurse practitioner, nurse midwife, or physicain assistant *of the same cultural background.* The harmony and effectiveness of such partnership falls under the jurisdiction of the Circle of Elders. Such organizational structures as the Circle of Elders and the community participation process should remain those integral to the traditions of that culture.

cultural healing

3. The education of health professionals in cultural health practices consists of teaching them the process of reconnecting to their own culture and becoming aware of the cultural underpinnings of their habits, decisions, attitudes and definitions of health and disease. The study of the cultural specificity of modern western medical science and its limitations both within and outside that culture is also required. Only then will the health professional be able to acquire the listening skill needed to hear another culture within that culture's context. Only then will the education of the health professional lead to cooperation, cross-referrals, and co-management of patients between physicians and cultural healers for the benefit and best outcomes for the patients.

In making my recommendations, I would like to be as simple and direct as my people in Haiti: Let us build for the people the roads that they are asking for. And let us have the humility to stand back and watch their wisdom flourish into the attainment of health the complexity of the determinants of which defy our analysis, the simplicity of achievement of which lies in their wisdom ways.

37. Thupten Dadak
Tibetan Buddish Scholar, Tibetan American Foundation of Minnesota

NOTES:
Brief statement about Tibetan medicine, research with same, and East-West medical research collaborations. Necessity of keeping Tibetan medical info in public domain.

38. Master Chunyi Lin
Spring Forest QiGong, Inc

39. Jose Reyes
Itzamatul Itolixtli Danzantes

NOTES:
As an Indian Elder, I would like to speak about the fact that we have been practicing this medicine for thousands of years and I am concerned that any type of "regulations or restrictions"will threaten Sacred Native healing tradtions and make our healers liable to government laws & santions.

40. Sabina Pello
American Association of Immigrants from the former USSR (IL Branch)

2:10 – 2:50 p.m. III Regulation

41. Tom R. Hiendlmayr JD
Minnesota Department of Health

42. Michael Myers, JD
Chair of Health Services Administration, University of South Dakota

43. Michael Morris Kleiner, PhD. certification rather than licensure to track training (registration?)
University of Minnesota

44. Rob Leach
Executive Director, Board of Medical Practice

45. Rebecca Frost, RMT,CMT
Liaison for Regulatory Affairs of ISMETA, Joint Government Relations Committee of the Federation of Therapeutic Massage, Bodywork and Somatic Practice Organizations

NOTES:
I am the Liaison for Regulatory Affairs of ISMETA (International Somatic Movement Education & Therapy Association), which is based in Washington DC. As part of my responsibility as Liaison, I represent ISMETA on the JGRC (Joint Government Relations Committee) of the Federation of Therapeutic Massage, Bodywork and Somatic Practice Organizations. The JGRC is a key committee which responds to arising needs in legislative arenas. We -seven members-routinely are the professional colleagues who are engaged by our constituencies to approve legislative language for bills being introduced into legislatures around the U.S. This involves monitoring regulatory movements nationwide, and crafting exemption language when appropriate. The JGRC is a unique forum for dialogue between modalities which otherwise might not occur and for creating arcs of understanding which previously tends not to exist. It is also a key body for conflict resolution.

In looking over the agenda for the day, I don't see representation of the somatic field. Somatic practices are often on the cutting edge of the complementary field, helping to shape and herald the consciousness that will emerge in the subsequent generation of alternatives. So you have a sense of the field, I provide a list of organizations below, some of which may be familiar, others which are emerging in poplularity.

My credentials also include serving, in 2000, on the Cultural Competence Subcommittee of the Primary Care Education Committee for the University of Minnesota Medical School. I also co-chaired the Law and Health Policy Committee for the Powderhorn/Phillips Cultural Wellness Center during its inception. I have tracked the various 'CAM' regulatory processes in MN for many years, including attending all the meetings of the legislatively mandated study of CAM by the

Dept of Health, and the previous roundtable meetings of the Board of Medical Practice while considering licensure for midwives. I testified re. licensure of massage therapists to the MN State Legislature in 1998.

46. Marillyn Beyer R.N.BSN, MA
President, Mn.Natural Health Coalition

NOTES:
We want to participate in the development of a healthcare plan that meets our needs.We want to choose our primary care provider from either allopathy or natural health.We want to choose our providers on the basis of outcomes/how much they have helped us.We do not want arbitrary educational standards applied.NO licensure.

2:50 – 3:30 p.m. IX Minnesota Legislation

47. Diane Miller, JD
National Health Freedom Coalition

(Background materials and talking points attached next page)

3:45 – 4:20 p.m. OPEN SESSIONS

53. Susan Marie Hageness, MA, RN
Children's Hospitals and Clinics

NOTES:
Children's Hospitals and Clinics Integrative Medicine Program has offered CAM services to children and families for over two years. Access, delivery, and re-imbursement issues for CAM services has played a crucial role in the development and continued functioning of our pediatric integrative medicine program. Our program has gained knowledge and insight into the provision of pediatric CAM services, as well as encountering some of the barriers in delivering pediatric integrative care.

54. Pamela Lou Ahrens, MA, Library Science
Children's Hospitals and Clinics

NOTES:
Children's Integrative Medicine promotes knowledge-based care and facilitates the sharing of information among all participants throughout the patient care process, including families, physicians/practitioners, researchers, nurses, and allied health professionals. We are therefore concerned with access to appropriate information resources, as we actively monitor and evaluate information in order to make informed decisions and explore/define evidence-based treatment options for our patients.

As a master's prepared medical librarian, and in my role as Family Information Specialist for Children's Hospitals and Clinics Integrative Medicine Program, I understand the power of information in knowledge-based health care. Appropriate, "righteous" information is a key element of our care delivery, and the sharing of that information involves all participants in the patient care process, including our families, the physicians and community practitioners, researchers, nurses, and allied health professionals, in order to make informed decisions and explore or define evidence-based treatment options for our patients.

Based on patient surveys conducted in our clinics, almost 60% of our patients' families are already using CAM therapies with their children, and there seems to be very little reliable or useful information on pediatric CAM modalities. Our mission is to offer safe, effective CAM treatment choices that can also be integrated with the specialized care our patients are already receiving at Children's Hospitals and Clinics. For our providers and for our consumers, we look for quality information on a daily basis about clinical trials, dosing, adverse effects or interactions, treatment guidelines or options that may be specific to children, as well as herbs/vitamins/supplements/ immune boosters or other CAM products and therapies that are so readily available to everyone now.

We are accustomed to the quick access of electronic information retrieval, and want efficient networks for sharing information, data and experiences that may be of value to others in the pediatric CAM world. We struggle with the quality filtering or evaluation of the information we do find, as well as with the regulations or controls that limit the amount of useful information that is available to us, when we are making health care decisions for patients.

55. Bob Michael Barron, R.N. ADN
Wellness Educators

NOTES:
The American public has overwhemingly shown a desire to more fully utilize CAM. Health care providers need to continue to advocate for the safety of the public in relation to this trend by becoming better informed. 2. In the debate over funding a prescription drug benefit for the elderly no mention is made of the many safe and inexpensive CAM practices available.

56. Kate Birch AS, RS Hom(NA), CCH, CMT
Minnesota Homeopathic Association

NOTES:
Concerning the public educational systems and how the basic tenents that are taught with regards to health and healing, limit our cultures view of healing. In this way the public as a whole is denied access to the concepts of healing employed by most CAM practices. I will discuss how the public school system can incorporate CAM practice concepts into the educational field so the right to choose the particular CAM practice will be made easier.

57. Ann Catherine Richtman J.D.
Northland Natural Health Resources, Inc.

NOTES:
I am an attorney who was a legal consultant in the Minnesota 146A legislation and I have also edited a 100-page publication on CAM for distribution in northern Minnesota and Wisconsin. My remarks and recommendations will be directed to ethical and legal principles foundational to the provision of health care; and access issues in rural areas.

(TESTIMONY attached next page)

58. Tenby Owens Master of Pulse Diagnosis
St. Luke's Center for Holistic HealthCare

I have been a student with Dr. Leon Hammer for more than five years. He is a retired Psychiatrist. In the course of his career he shifted away from his allopathic training to address his patients' ailments to methods based on Chinese medical physiology and practice (acupuncture and herbal medicine). A genesis of his lifelong exploration has been his development of what is now known as Contemporary Chinese Pulse Diagnosis. This is a specialized method of pulse taking that is not taught in Oriental Medical and Acupuncture Training Programs. I am one of a group of practitioners who are faithful to this diagnostic method used for developing treatments for my patients. I am an herbalist. Others who use this method are practicing acupuncturists. Robert Heffron, M.D. has been teaching this method to a handful of medical physicians, most of who work in Europe. This system lends itself to an apprenticeship method of teaching and learning so we study with Dr. Hammer twice a year to refine our pulse taking and interpretation skills and share our experiences on an ongoing basis.

It has become clear in this five year period that this inexpensive and noninvasive diagnostic method shares a fascinating and important interface with allopathic medicine, namely that all of us are finding what are "undiagnosed" significant health problems of patients who come to us for services. Some examples of this include undiagnosed diabetes, cancers, heart disease, hepatitis, duodenal ulcers, and brain abnormalities such as strokes. We are seeing the correlations between our pulse findings and Western diagnoses because our findings are later confirmed by relevant allopathic tests.

We have concluded that it is important for us to take a first step in compiling our findings; that is creating a database so that we are systematically documenting these occurrences. The importance of this systematic collection is to demonstrate that a finding of mine is not an isolated event or for that matter of any one of us where ever we happen to be practicing. Rather it demonstrates the integrity of the Contemporary Chinese Pulse Diagnosis system that we have learned. Our belief is that we can later access this data so as to create a body of knowledge that correlates pulse findings with Western disease diagnoses in such a way that will be meaningful to the allopathic medical community. This is a first step to introducing, if you will, this pulse system to a skeptical medical community.

This pulse diagnosis system is much more than this common ground I am describing. It stands alone as a diagnostic method and its real strength is in prevention and early intervention of disease processes. However, the realm of prevention and early intervention is still too vague for the current American healthcare system to recognize as meaningful. That being the case, the place to begin is where we share common ground.

Research moneys are not readily available to practitioners and schools of thought that are not already part of the mainstream of healthcare. Understanding the benefit of a diagnostic method such as Contemporary Chinese Pulse Diagnosis is not going to happen in an environment of skeptics. Rather, it will grow out of the community of practitioners who use it and understand its importance and who are then able to bring it to that skeptical community in a systematic way. We ask that you recognize this and widen your scope of how funds are made available to practitioners of so called "alternative" medicine.

4:20 – 4:55 p.m. Open Sessions (continued)

59. Howard Figler, DC
American Chiropractic Association

60. John E. Toft D.C.
Functional Medicine Chiropractic Center

NOTES:
I am using a model of Chiropractic health care similar to Alternative Medicine Inc.'s Docs. I am concerned with patient coverage for my time working with 'wellness' care, coverage for nutritional supplements, and when necessary, the Functional Medicine lab tests that I use from Great Smokies Diagnostic Lab. I am also very concerned with the quality of nutritional supplements that people are buying 'off the shelf' that are of very questionable quality in purity and potency.

TESTIMONY:
I am practicing a model of health care that combines my Chiropractic training with the most current, cutting edge, medically based and referenced research of Functional Medicine; delivered through a very specialized arena of Chiropractic, Applied Kinesiology. This is essentially the model that is being used at Alternative Medicine Inc (altmedinc.) that is performing in a pilot project with BC/BS of Ill.

check registration

In speaking with Dr. Steven Groft I believe you folks are aware of this pilot project, but may not have seen the most recent numbers. They are now showing after two years of treatment a 66% overall health care cost savings. Dr. Richard Sarnat will be coming to you in Washington next month to speak about this program, and I hope you will give him special very special attention. One major item to me that has not been previously discussed is that what makes this group of specially credentialed physicians so effective is the very specialized technique of Applied Kinesiology, which the majority of the DC's in the group are using.

Applied Kinesiology (AK for short) is a diagnostic technique that has been evolving over the past 35 years. AK gives a practitioner the ability to find and fix the underlying causes of musculoskeletal problems, and also allows us to find the very specific nutritional deficiencies, food allergies, toxic conditions and also emotional issues that then enable us to fix organ systems that have lost their reserve energy, and are on a downhill ride towards an eventual disease state sometimes decades in the future.

The Human Genome Study has shown that disease exists on the genes. What Dr. Jeff Bland's work has shown already years ago is that the combined effects of environment and lifestyles is affecting communication molecules that turn the diseases on or off at the level of the chromosomes. The expression, or phenotype of the genes is controllable.

I have included, as you have been informed by Michelle Chang, a work product of mine on 10 floppy cassettes nearly 500 medically referenced articles in 44 categories of disease that educate one on how the whole body works together in health and disease. I hope that your commission can spend some time with this cutting edge material.

I feel that this is the most exciting time there could ever be in health care. We are showing an absolute revolution in the health care delivery process; from a disease care model to a truly preventative model that can find and fix organ system weaknesses before disease has a chance to develop.

I have included several additional writings of mine, and will be more than willing to assist you in any way I can. Thank you so very much for coming to Minnesota to hear us.

61. Marilynn Rose Anderson
The Feldenkrais Guild of North America

62. Chu Yongyuan Wu, MA
Hmong Shaman Research Project

NOTES:
Will share the traditional Hmong healings and herbal medicines in Minnesota.

63. Jeffery Dusek PhD
Mind/Body Medical Institute

NOTES:
Introduction ... Many Americans use non-traditional medical practices. Unfortunately, mind/body medicine is often grouped together with CAM. There are, significant differences between the two. 1. Like mind/body medicine has done, CAM must be expected to adhere to the same scientific rigor expected of traditional medicine.

64. Richard Rainbow Pavek
The SHEN Therapy Institute

NOTES:
Without protecting the freedom for practitioners to deliver the minor CAM methods and practices to the public, these methods and practices will continue to be slowly outlawed by the different state's medico/legal authorities. The White House Commission on Complementary and Alternative Policy needs to strongly endorse national legislation similar to the groundbreaking Minnesota Health Freedom Act. This action is vital to the best health interests of the American people.

4:55 – 5:25 p.m. Open Sessions (continued)

65. Larry Paul Caldwell, MS in Oriental Medicine
Acupuncture Association of Minnesota

TESTIMONY:
Good afternoon. My name is Larry P. Caldwell, Doctor of Oriental Medicine, Licensed Acupuncturist, President of the Acupuncture Association of Minnesota.

On behalf of the members of our association I would like to present the following information regarding the useful, reliable and updated information for the practice of Oriental Medicine, otherwise, known as " Acupuncture ", in the State of Minnesota.

Currently, there is considerable confusion regarding the scope and practice of "Acupuncture" here in Minnesota. I use this word because it has become the household term to describe the complex and comprehensive field of medicine which is founded on Traditional Chinese Medicine.

Acupuncture has been used to describe the use of needles placed into the body to relieve pain and treat other maladies. Upon further inspection, you will see that there is an entire infrastructure of medicine designed to produce far more profound results than pain relief.

That infrastructure includes private schools which provide Master Degree Programs in Oriental Medicine, State testing programs and National Accreditation programs to ensure the quality and high standards for competent and well educated practitioners to utilize the full potential of Oriental Medicine.

Our Association is dedicated to promoting education and literature to the public indicating the differences in programs offered to others who use the term "Acupuncture" in their practices. We feel that it is a public safety issue when practitioners are using a tool which is a component of a

complex medical paradigm with little or no training. Our education and regulation system has evolved over the years to provide the public with quality practitioners who can deliver an alternative form of health care.

The key here is the use of the word Alternative. Our medicine provides a necessary option to the public for a wider scope of health care. We do not believe our medicine is meant to act alone but as a component of a larger system which allows for the individuality of each system in order to promote the most effective and safe health care to the public.

We see each person as an individual with unique qualities which express disease or ailments uniquely unto them. Considering the environment, the eating habits, the amount of exercise, the amount of stress and how an individual copes with the stress in their lives, our diagnostic tools allows us to approach each person with a treatment plan specific for them.

Through the use of our medical paradigm we have been able to help many who have come to us as a last resort. These people who seek out alternative medicines have utilized conventional medicine without satisfactory results. They pay for treatments out of pocket because of the lack of third party reimbursement participation. This is an indication that one system does not work for all.

For instance, here in Minnesota, acupuncture is reimbursable if administered by a Medical Doctor or a Doctor of Chiropractic but not a Licensed Acupuncturist by many third party payers. It is ironic that the practitioners who have the most knowledge and day to day experience cannot partake in the conventional system.

Our Association has produced a Membership Directory, Newsletter, and now a website to inform the public on what Oriental Medicine is designed to do, who can practice the medicine and what level of education the practitioner has to have to practice, " Acupuncture".

We would like to see a refinement and more precise definition of the information the public is receiving under the moniker of Acupuncture. It is hoped that through these testimonies you will see there is more to our medicine than simply placing needles into the body.

Thank you for this opportunity to express our views.

66. Zhaoping Li M.B. (China), L.Ac. (MN)
MN College of Acupuncture and Oriental Medicine, Northwestern Health Sciences University

NOTES:
I have helped patients in my practice of acupuncture & Chinese medicine in the U.S. since 1990. These patients should have access to reimbursement for treatments that have proven to be effective for conditions that Western medicine has found to be intractable or could not treat without surgery or expensive medications. I practiced in a hospital in China from 1972 to 1989. I specialize mainly in pain management, women's health care, and difficult cases. Sen. Mark Dayton was my patient.

TESTIMONY:
My name is Zhaoping Li. I am a Doctor of Traditional Chinese Medicine. I have practiced TCM in China since 1972 and the Twin Cities since 1990. I am credentialed by Health East and Children's Hospital. I have 3 years of Western Medicine Training and 5 years of TCM training from universities in China. I teach TCM at a Masters Degree four-year program in Minnesota.

My mother is a retired western medicine Gynecologist in China and also has had TCM training. Because of her excellent TCM results with her patients, she encouraged me to study and practice TCM. My uncle is also a well-known TCM Doctor and past President of an acupuncture institution in China. I have both been trained by him and helped him to train many international students.

In China there are Western Medicine Doctors and TCM Doctors. They always work together as a team. One example is for cancer patients. TCM is very good at dealing with the side effects of chemo and radiation therapies, especially nausea, fatigue and lowered white blood cell count.

We tried this team medical model at Health East Healing Center here in Minnesota. The patients benefited greatly from this combination of treatments! But, because of insurance reimbursement issues for TCM, the center closed after one year.

TCM is beneficial to both patients and insurance companies. As an example, I have many patients who were advised to have a hysterectomy because of heavy menstrual bleeding. With TCM, their symptoms so lessened that they were able to cancel their surgery and expensive medication!

I recently have been treating a 14-month-old baby with glycogen storage disorder. The parents were told there was no hope – they were advised to put the baby under hospice care. His muscles were so weak it was difficult for him to breath. There was no movement in his limbs and he was constipated. After just two treatments with TCM he now has significant movement, regular bowels, responds more and even smiles. Unfortunately again, the insurance companies won't cover TCM treatments for this boy.

This is a very important point. TCM patients must have access to reimbursement from insurance companies. It is time for TCM treatments that work effectively to be recognized as valid by the insurance industry.

Thank you very much for listening.

67. Changzhen Gong, PhD, MS
American Academy of Acupuncture

(Testimony attached next page)

Traditional Chinese Medicine: Its Practice, Education and Research in the United States
(draft)

Changzhen Gong, Ph.D., MS

American Academy of Acupuncture and Oriental Medicine (Minneapolis)
Asian-American Acupuncture Association (Chicago)

Traditional Chinese medicine is a science of Eastern wisdom of health and healing. It is a complete system of medicine, not just a therapy. It covers the whole range of health conditions, not just a few health problems. It is in the best interest to preserve the integrity of this time-tested medicine, keep a high standard of professional education and develop valid research protocols on acupuncture and Chinese medicine.

Preserve the Integrity of Traditional Chinese Medicine

The vitality of traditional Chinese medicine relies on the holistic philosophy, pattern differentiation and clinic effectiveness.

Holistic Foundation: Chinese medicine views the human body in a very different way from other medicine. The system is internally consistent, coherent and built practically upon the "cosmological basis" of Yin/Yang, and Five Elements. This also provides the basis for Chinese medicine to be able to offer many unique and highly effective therapies for many conditions.

Pattern Differentiation: Stressing treatment of different individuals based on their specific clinical manifestations and response to diseases serves as the core of Chinese medicine diagnosis. Any simplification by giving up pattern differentiation will reduce the clinical effectiveness.

Clinical Effectiveness: Clinical effectiveness has made the Chinese medicine flourish and thrive several millennia. This depends on the consistence of the theory, treatment principles and treatment modalities. Without a systemic knowledge of Chinese medicine, it is impossible to provide the best Chinese medicine care with the maximum effect.

Keep High Educational Standard

NCCAOM Entrance Standard: NCCAOM has developed certification standards in acupuncture and Chinese herbology. Practitioners should have a complete and systematic basis of Chinese medicine theory and the basic skills for diagnosing and treating commonly seen conditions. We support that NCCAOM certification standards should be used as a general standard for the professionals who provide acupuncture and Oriental medicine services.

Complete TCM as the Base for Doctoral Program: World-wide only the system of traditional Chinese medicine, its institutional establishment and educational structure are parallel with and equivalent to modern Western medicine. Practice-oriented doctors of Oriental medicine should be able to analyze and treat common and complicated health conditions with major Chinese medicine modalities, based on a solid and complete knowledge of Chinese medicine theory.

Develop Valid Research Protocols

Western Medicine Research Approach to TCM. Western medicine based research provides some insight toward demystifying this thousand year healing tradition. But this research is limited in discovering the working mechanism of Chinese medicine which is rooted in holistic concept and pattern differentiation.

Eastern Medicine Research Method. Beyond traditional Chinese medicine research tools, researchers should develop new research protocols to validate those effective treatment procedures. Those research methods should incorporate the fundamental principles of traditional Chinese medicine: holistic concept and pattern differentiation.

Chinese Medicine Literature Translation. Five thousand years of medicine accumulated a vast amount of literature from classical texts, anecdotes to modern research. Translating the existing research literature from Chinese into English will benefit both the profession and the public.

68. Jennifer Blair Diploma in Oriental Medicine
Acupuncture Association of MN

NOTES:
Using case histories, I will show that Chinese Medical diagnosis offers a holistic view of the body, providing patients with an understanding of how disparate symptoms interact. This helps patients manage symptoms with diet lifestyle, and home care in addition to their medical treatment. Patients are given tools with which they can promote their own health and reduce their dependence on medications, surgeries, and other costly interventions.

69. Ike Rodman Ph.D. (not in health care)
College of Acupuncture and Oriental Medicine, Northwestern Health Sciences University

NOTES:
Topic: The federally- and state-recognized professional structure that already exists for Oriental medicine practice in the United States: accreditation of education, certification of competency, and state licensure and regulation of practice.

5:25 – 6:00 p.m. Open Sessions (continued)

70. Gregory Vernon Schmidt M.F.A.
Mn Natural Health legal Reform Project, Vice Pres.

NOTES:
Standards only needed when no accountability for client-practitioner relationship exists. Mutual respect is the basis for any and all contracts where excellence is the norm and it cannot be legislated in or educated in if it does not exist in the beginning.

71. Leo Bernard Cashman BS, MA
DAMS, Inc, MN Natural Health Legal Reform Project

NOTES:
FDA, US Public Health Service and State Dental & Medical Bds are exerting a reign of repression. Support legal reforms to protect consumer access to all types of holistic, alternative health practitioners, stop govt collusion with ADA, AMA, pharmaceutical and insurance.

72. ~~Amrit Devgun ND~~ Allen Anderson
Santulan Health Center

73. Gayle Bowler
Minnesota Natural Health Coalition

NOTES:
Protect my right to access to CAM. Protect rights of licensed health care providers to discuss CAM. Provide for easier access to information about herbal preparations. Government should provide research on CAM Don't ban herbal remedies. Teamwork needed between traditional health practices and alternatives.

74. Jeanne M. Hollingsworth
Mn. Nat. Health Coalition

NOTES:
As a consumer I believe strongly in being able to go to the natural health care practitioner of my

choice regardless of their academic training. As a consumer I want to keep my freedom to choose.I fully support the bill that was passed in Mn.

75. Nancy Gay Hone B.A. Nursing and M.A.T.
Mn. Natural Health Coalition

NOTES:
As a cofounder of the MNHC and MNHLRP, both grass roots groups that passed a bill to free consumer access to the the natural Health care practitioner of their choice, I think the citiznes need a voice in the commissions process.

LETTER TO COMMISSION:
March 6, 2001
Minnesota Natural Health Coalition Recommendations to the White House Commission on Complementary and Alternative Medicine

WHO WE ARE: We are a nonprofit, Minnesota, grass roots, citizen based group that decided we wanted legal access to the health care provider and modality of our choice. We formed this group in 1996 in response to sanctions placed upon several licensed as well as unlicensed providers of alternative therapies in the state of Minnesota. This was in addition to the persecution of natural therapies that has gone on for hundreds of years. These are some of the factors that influenced our group to decide to educate the public that there is a problem so that action could be taken to change the political environment of suppression of alternative health care options.

The following are statements from this citizen group to tell this President's Commission what problems citizens recognize, what principles we stand for and what we recommend for your consideration.

******EVERY PERSON SHOULD BE ABLE TO HAVE ACCESS TO THE TYPE OF HEALING OR HEALTH CARE THEY DESIRE AND THE PRACTITIONER THAT THEY HAVE DECIDED UPON REGARDLESS OF THEIR ACADEMIC BACKGROUND.

*****Every person has the basic right of self-determination and the right to make their own personal choices in the process of their healing. This decision is the most personal decision a person can make. We as citizens are ultimately responsible for our well-being.

****Every person has the constitutional right of access to any healing or health care practitioner, treatment, or information source that they desire. They have this right regardless whether the treatment they seek is societally acceptable, well known, "scientifically proven" or generally recognized and regardless of the practitioner's education, training and experience.

Regulations

Problems:
1.)Unlicensed practitioners can be charged with practicing medicine without a license.

**Health freedom legislation is needed in each state so that practitioners no longer have to live in fear. This is essential so that all practitioners of alternative therapies remain available to the citizens in order that their options are complete.

2.)Licensed practitioners can be sanctioned for practicing outside their"standard of care" which is not something that is even written down.

**Medical, dental and other state health boards should be made accountable to the citizens of their

states and eliminate the undue influence of politics in the appointment of these board members.

3.) Now that alternative health has statistically shown to be popular by the citizens, efforts are being made to regulate it and set academic standards attending to the false assumption that the citizens need to be protected.

The citizens are not asking for protection. They are asking for freedom to access who they want to in their health care decisions.

Solutions:
Change can be accomplished by being certain that it is no longer illegal for natural health practitioners to practice. Any new laws should allow for the greatest amount of innovation and ensure that there is a legal environment established for the consumer to access the health care modality and practitioner of their choice regardless of their academic background.

*Natural Health therapies have been used since the beginning of time. They are extremely safe, non toxic and non-invasive. In fact, most aspects of natural health have existed in some form since, if not before, the advent of man. Animals certainly ate specific plants to ameliorate certain conditions. A lot of ideas man has learned have come from observing animals.

* The biggest obstacle to the access of natural therapies has been legislation that has been passed in medical statutes throughout the country in the 20th Century. These statutes have overly broad definitions of the practice of medicine prohibiting "the unlicensed practice of medicine"

This made it illegal for most people to practice the natural healing arts unless you were a licensed physician.

The medical statute in almost every state contains an overly broad definition of the practice of medicine. They are mostly similar to the statute in Minnesota , Statute 147 Subdivision 3(3) which states that anyone who "offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, or defect of any person;" is practicing medicine and must be licensed to do so.

*Before these monopolistic laws were passed in America, many people assisted others in their health by using herbs, foods, homeopathy, water therapies, and many, many other healing modalities. However, as medical licensing statutes evolved, it eventually became a criminal offense-the "unlicensed practice of medicine" -to help people get well and to even prevent disease, unless one was medically licensed. As a result what we today call "complementary and alternative " forms of health care almost entirely disappeared from America early in the 20th Century.

*These laws were passed with the false assumption that licensing protects people from quacks.

*In our research, we found that licensing has not proven to protect the public. In fact, licensure has historically been sought by a small group of individuals to secure an economic position in the marketplace by setting up a system of exclusivity with monopolistic practices.

*Government regulation such as licensing and registration sets up a false assumption that certain academic criteria are required for assisting someone with age old wisdoms of health care. In a well meaning attempt to support the growth of natural therapies, we may create a nightmare tangle of regulations and requirements that end up destroying the spirit of natural health care.

*Any government regulation should be to protect citizens rights to individual choice and autonomy and to protect them from harm.

**The government should never use its police power to shut down practitioners where true harm is not an issue. The use of or the practice of natural therapies is not in and of itself harmful. The public is only protected when it has the freedom to make their own choices and not forced to participate in expensive, toxic, or surgical methods when other options are available.

**State and federal governments must be vigilant during health care reform to preserve the balance between government regulation and an individual's right of self determination and right of choice.

EDUCATIONAL STANDARDS

Problem:

Government mandated educational standards for the broad domain of the healing arts can be very misleading to the public and unrealistic.It can subsequently limit consumer access to practitioners that do not abide by government mandates or do not fit the academic requirements set out.

Arbitrary numbers of classroom hours at selected types of educational institutions with the receipt of conventional types of academic degrees is set as a standard. Many forms of natural healing cannot be confined to traditional learning environments or classroom or textbook training--and indeed they need not. Practitioner effectiveness may depend on inherent giftedness in the healing art. Skills may be acquired by mentoring with an individual, self-study, or other unconventional methods. Attempts by the government to quantify effective preparation needed for a particular healing art may restrict the pool of practitioners and may only serve to eliminate some of the most effective healers and therefore consumer access to them. Government mandates may miss some of the more intuitive or spiritual dimensions of healing skills which may not be easily defined or tested or even taught in an academic setting.

Solutions:
**Governments should provide a legal environment in which all practitioners of alternative health can practice regardless of their education and training as long as they practice within reasonable conduct guidelines and provide consumers with an informed environment. This will ensure maximum consumer options.

**No restrictions should be put on the dissemination of new ideas and information if there is informed consent.

*** A free and uncensored society is essential to the preservation of wisdom and knowledge of ancient healing arts.

RESEARCH

Problem:
Double blind scientific method studies do not generally apply to natural therapies. Each person is recognized as different. There is no money in not being able to patent nature, therefore, grants are not usually given for this research.

Solution:
Creative research needs to be entertained. Consumers tell us that they do not need double blind studies to inform them of their choices. Consumers cannot wait for research.Today, we have an enlightened public that is aware that medical research has failed them. They are simply observing, reasoning, and finding out what they want to know on their own. Research for natural therapies could use some government funding, however, because private industry will not set aside money for something they cannot get a big fiscal return on through patent. An herb cannot be patented. It was made by God.

CONSUMER ACCESS/REIMBURSEMENT

Problem:
It is difficult for citizens to pay for standard medical insurance and then have to pay out of pocket for their alternative therapies. Citizens are forced into toxic and surgical procedures because that is what their insurance will pay and they were not given any other options. In addition, citizens often turn to alternative therapies when standard medicine does not offer them the help that they need. Many people even choose solely to go to alternative therapies while paying big insurance premiums that they will only use in catastrophic circumstances. Their premiums are going higher and higher and their needs are being met less and less. The citizens are not happy with managed care.

Solutions:
As citizens in Minnesota, we think we have opened the door to access of complementary and alternative healing practices and interventions by educating the public that there was a need to effect change. The result in Minnesota was that the Minnesota Natural Health Legal Reform Project passed innovative first of its kind legislation that was signed into law on May 11,2000 to free access to all of natural health in the state of Minnesota. See Minnesota Statute 146A.

*The reimbursement discussion can only take place after it is made legal to practice complementary and alternative therapies.

There is a great deal of evidence that the practice of natural therapies through health promotion as well as disease intervention is so much less costly and more cost effective.

All complementary and alternative practices by all practitioners should be reimbursable through federal programs and other health care coverage systems. As consumers, we want to make the choice of what works for us.

****We believe creative and new ways at looking at reimbursement other than a false reading of educational standards needs to be looked at as to which practitioner's work is covered by insurance. Old ways are for the old system. New ways are for a new paradigm of healing.

CREATIVE IDEAS FROM CITIZENS

Just some of the ideas from citizens thinking outside the box for a new paradigm of health care include:

1.)a voucher system that could be bankable and transferable to those in need if you did not use them. 2.)medical savings plans 3.) a tax deduction 4.) insurance coverage for more wellness education using alternatives so that major medical insurance only needed to cover catastrophic problems as people learn to practice a higher state of wellness.*Education of the consumer puts them on a more equal basis with their professional and empowers them. 5.)community health plans in which the citizens of a community decide what is offered in their health plan. Start up funds would be needed via grant money for example. 6.)No therapy should be denied coverage just because research has not been done on it. 7.)Approval of therapies could be given on outcome based data. This can include case studies submitted by a practitioner or a professional group. Ideally data comparing the natural therapy to the standard medical therapy will include both costs and outcomes. 8.) Two choices of coverage, standard medical care or alternative health care options, could be made available to all individuals. The citizen would select the type of primary care provider that has produced the best outcomes for themselves and that they have the most faith in. These two plans would cover subacute and chronic conditions . A major medical plan would be offered to cover trauma, premature delivery and birth defects. This plan would continue to be the primary coverage but expand it to include another additional option.

9.) A citizen should have the option of switching to another form of coverage if they are not being

helped to their satisfaction.

10.)All health practitioners should be able to offer all of their skills and knowledge that they possess. Anything less is robbing the consumer. Citizens should be able to decide which practitioners they go to regardless of their academic background. Reimbursement companies could look at outcomes to decide coverage.

DELIVERY OF RELIABLE AND USEFUL INFORMATION TO THE PUBLIC

Problem:
1.)Natural health information has been suppressed for a long time in the media and the standard medical community by consistently denigrating alternative health care as a whole.

2.)The FDA is too involved with the biopharmaceutical industry to be an objective watchdog to information disseminated to the public.

Solutions:
**We believe, as consumers, that reliable information is everywhere and could be improved by allowing more freedom of speech by everyone involved with the dissemination of natural therapy information.

** We would like to see the media present more fair articles on natural therapies without denouncing them.

**We would like to see the Dietary Supplement Health and Education Act strengthened to provide more truthful information on products.

** We would like to see the revolving door of the FDA and the pharmaceutical industry employees locked.

**We also would like to see that the standard medical community be more versed in alternative therapies so that they can present us with options other than standard medical practices.

***We would like to see lists of alternative practitioners in their offices as healthcare options for citizens to go to as well as alternative therapy information provided in their offices via unbiased articles, etc.

*** We would like doctors to be self informed about the complementary and alternative therapies that we are going to so that they no longer fear the unknown.

We would like to leave you with this thought:

"A free society has a great stake in protecting the unorthodox. It is through unorthodoxy that society grows. If unproven avenues are blocked, what remains is already known and both progress and freedom are lost. Today's orthodoxy was yesterday's heresy and yesterday's orthodoxy is today's superstition. In today's 'quackery' lies the emergence of future enlightenment. In the ultimate, the suppression of the freedom of one individual creative mind will kill more people than all the government programs will ever save."

--The National Health Federation Bulletin, April 1980, author unknown

The Minnesota Natural Health Coalition Recommends that Minnesota Statute 146A , the Minnesota Complementary and Alternative Health Care Freedom of Access Act of 2000 be referred to for concepts congruent with the above statements.

ANCILLARY COMMENTS (from observers)

The Healing Point TRADITIONAL ACUPUNCTURE CENTER March 5, 2001
To the White House Commission on Complementary and Alternative Medicine Public Comments

My name is Edith Davis, and I am an acupuncturist. I was one of the original developers of national board certification, which is now the major criterion for licensure in the U.S. I was the founder and past president of the Minnesota Institute of Acupuncture and Herbal Studies, which is Minnesota's only accredited school of Oriental Medicine offering a Master's degree. I am a current member and a founder and past president of the Acupuncture Association of Minnesota. And I am director of an active clinic. So you see that I speak from a wide range of experience.

I wish to address the problem of access to alternative or complementary health services in general, and to acupuncture in particular. It is well established that there is a broad interest in alternative health care. One of the major barriers for consumers is, paradoxically, the health insurance system. In our clinic we find that persons who want to utilize our acupuncture and Oriental medicine services are deterred because their insurance will not reimburse us. We are frequently told that their coverage includes acupuncture performed by medical doctors, or by chiropractors, or even in one case by physical therapists, but not by our staff of licensed acupuncturists.

The logic of this policy escapes me. With due respect to the members of other professions and their knowledge and skills in their own fields, licensed acupuncturists are the only ones with thousands of hours of education and clinical training in Oriental medicine, and yet they are excluded in most insurance programs. This is compared with the limited education and training that members of other health professions might have obtained, which could be as little as 12 hours or at most a couple of hundred hours.

This is a major barrier to the consumer who would have to pay out of pocket for the treatment of choice, but who has already paid once for generic health care coverage. This includes a barrier to the doctor's recommendation as well as the patient's individual choice. There are some simple solutions for this particular barrier to access. First of all, some states such as California and Washington require insurance companies to cover the services of licensed professionals if those same services are covered when performed by members of other licensed professions. In other words, if an insurance company covers acupuncture done by a medical doctor or a chiropractor, they would also be obliged to cover it when done by an acupuncturist. Inclusion of acupuncture in federal programs such as Medicare and Medicaid and in the various state programs is another obvious way of expanding access for those who choose these services. For persons on Medicare or Medicaid, the denial of coverage is even more critical, because those with lower incomes are even less likely to be able to obtain out-of-pocket services.

Cost effectiveness is a critical issue in these times of rapid inflation of health care costs. This should be an area of research, but some "anecdotal" incidents in my own practice suggest the importance of further investigation. A patient who was scheduled for cervical surgery came for acupuncture as a temporary pain-relief procedure in the interval. When she returned to the surgeon for pre-op evaluation, she was told that she no longer needed surgery. Another patient had a history of several hospitalizations for intestinal blockage. After just a few acupuncture treatments, she never had another incident of blockage, despite the fact that the primary cause of the blockage (a malignant tumor) had not been changed, and actually was the cause of her death about six months later.

The cost of one day's hospitalization could cover a full series of acupuncture treatments. The potential cost effectiveness of this form of health care deserves a serious look at ways for making the treatments more accessible, aside from any moral issues around ensuring people's freedom of choice of styles of health care.

Testimony
Submitted to
The White House Commission on Complementary and Alternative Medicine
in support of their
Minnesota Town Meeting

Submitted by
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March 12, 2001

To the Commission:

I present testimony as a newcomer to the CAM field. My most extensive training has been in the fields of physics and mathematics (PhD in physics, University of Minnesota, 1969), and for most of my professional career I have taught physics at a small Minnesota university. I "repotted" myself into CAM only a few years ago, for a number of reasons:

a. I realized there was no requirement that I teach physics for the rest of my productive years, and that due to my "hard science" background, I could retrain in virtually any science related field I wished.

b. While the U.S. has made great strides in "fixing" serious medical problems such as heart disease, medical care for many chronic conditions leaves much to be desired. It appeared that I could contribute to the wellbeing of my community as a CAM worker, and I chose to specialize in energy medicine. I now do qigong healing work with clients in Minnesota and other states.

So, what can I share with you from my tiny office on the prairies of southwest Minnesota? As a former scientist, I offer these broad observations:

A. Diversity in a system promotes stability of the system .

If there is no other reason for the existence of "complementary and alternative" practices in our health care system, this is it.

As any good ecologist is aware, diversity in a biological ecosystem is an excellent predictor for the long term stability of the system. Conversely, the lack of diversity is a certain indicator that the system, when confronted by a new predator, a climatic change or other "unforeseen" pressures, is likely to end in catastrophe. The pages of ecology textbooks are replete with examples such as the following:

1) The Chestnut Tree Blight

"The American Chestnut tree (*Castanea dentata*) once formed a major part of the eastern forests of the United States, including the Cumberland Plateau and the Scott's Gulf area in Tennessee. In fact, much of the surrounding area is recognized on U.S.G.S. topographic maps as "Chestnut Mountain" and "Little

Chestnut Mountain," a tribute to its once prominence in the area. In the 1880's, a fungus from trees imported from the Orient infected native American Chestnut trees and quickly spread, killing most native chestnuts and chinquapins. Large decayed remnants of these once giant trees can still be found on the Bridgestone/Firestone Centennial Wilderness.

"The American Chestnut was a large tree that had wide-spreading branches with a broad crown that reached heights over 100 feet. The nuts from the tree were large, sweet, and highly desired by not only people but deer, squirrels, turkeys, and other wildlife. Before the chestnut blight, the trees reproduced abundantly by both seeds and sprouts. Today, young American chestnut trees rarely survive long enough to produce the flowers and fruits needed for reproduction." (Bridgestone/Firestone) The chestnut tree forest is an example of an ecosystem which was not stable to invasion by foreign pests.

2) Southern Corn Leaf Blight

In the mid 1970's, a major fraction of the U.S. corn crop was wiped out by leaf blight disease, caused by a susceptibility of hybrid corn to the organism *Bipolaris maydis* Most of the hybrid seed corn then used had genetics so similar that the blight fungus found helpless victims all across the Midwest. Once again, in the presence of the right invader, there were catastrophic consequences because of the lack of diversity in the genetic base.

3. Dutch Elm Disease

"American elm is one of the largest, most impressive, and most abundant landscape trees .... The trees are relatively fast growing, they thrive on a wide range of soils, tolerate soil compaction, root disturbance, drought and extreme winter cold. ... American elm became the most widely-planted street tree in North America over the past century.

"...As with most things which seem too good to be true, American elm faces one major drawback. A well-established 100-year-old American elm can be killed in as little as two weeks if it is attacked by Dutch elm disease. The disease's arrival in Europe was marked by the sudden decline and death of millions of elms in the first two decades of this century.

"...After having decimated the elms of Europe, the fungus responsible for the disease was accidentally transported to North America in the early 1930's, when diseased elm logs were imported to America. Like the elms of Europe, the native American elm had no pre-exposure to the fungus, and was therefore highly susceptible to invasion. Soon after its arrival, decimation of elms in Eastern North America was begun. Since that time, the disease has proceeded along a steady westward course across the North American continent wherever elm trees grow naturally, or in cultivation. ... It was not uncommon for a city to lose 90% of its elms in as little as ten years leaving tree-lined streets suddenly transformed into empty wind-swept places. ... " (Dutch Elm Disease)

It has been said that had a diversity of trees been planted in our urban forests, the beetle's intrusion would scarcely have been noticed.

4. Honey bee Parasites

The susceptibility of honeybees (*Apis Mellifera*) to the infestation of two parasitic mites, the tracheal mite and the Varroa mite, has, within the short period of 10 years, led to a precipitous decline in the populations of pollinating insects for commercial crops, e.g. almonds, cherries, apples. In the U.S., it has been suggested that most colonies of honeybees have genetics that are traceable back to a relative handful of "breeder" queens. Once again, in the absence of diversity, the system is simply not stable against "intruders".

To **summarize**, while we might not understand the scientific or even philosophical underpinnings of many CAM practices, we live in an arena where new contenders for space in our health care "ecosystem" are constantly intruding, such vectors as "mad cow disease" and West Nile virus being only a few of the latest. Good practice dictates that we need to maintain a diversity of "tools" in our health care tool chest in order to respond effectively.

B. Good research, and honest, unbiased researchers, are hard to come by.

Some CAM methods are helpful; we don't know which; good research is needed.
Some "conventional" medical methods are helpful; we don't know which, good research is needed.

Generally speaking, "more information" is better. Good research is usually a good thing. However, there has been concern from early on that science is not as "pure" as we would wish:

"A scientist will never show any kindness for a theory which he did not start himself." (Mark Twain).

"It isn't what we don't know that gives us trouble, it's what we know that ain't so!"(Will Rogers)

We must watch not only the research methodology, but also the selection of researchers. Thomas Kuhn (1962) has said that a particular body of evidence doesn't fit the "normal" paradigm, its presence may be all but invisible to a scientist who is steeped in the current paradigm of his field. Robert Becker MD (1985), an orthopedic surgeon and brilliant researcher in the relationship of electromagnetic fields to the human body, describes the battles involved in research funding and recognition, and makes it clear that scientific politics and the existing paradigms play major roles in funding decisions for research. A recent article in the New York Times describes the manner in which promotional money from pharmaceutical companies attempts to sway the judgments of medical professionals (Peterson, 2000).

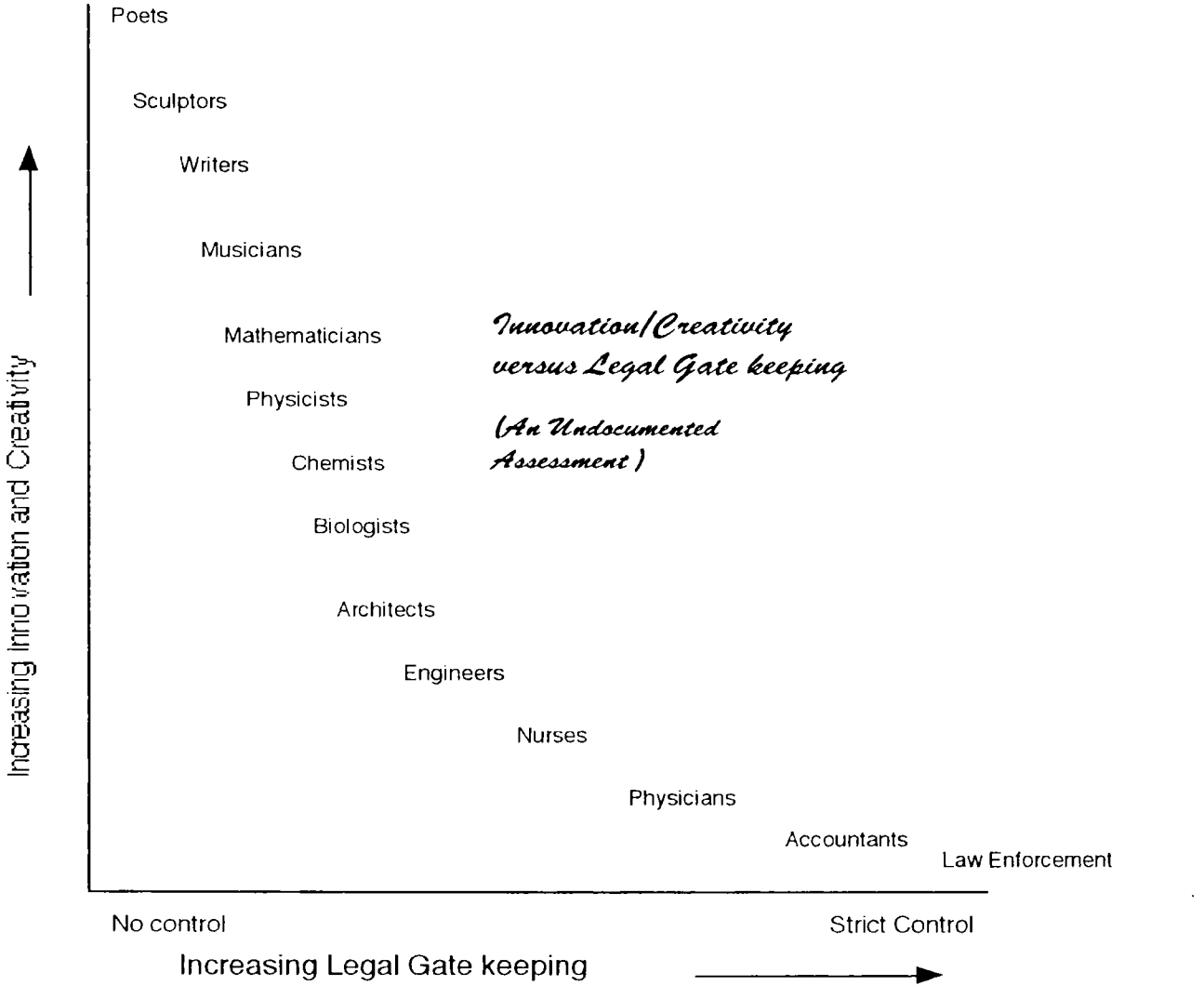
In summary, good, unbiased research is needed to support the many diverse tools in heath care **fair representation must be provided on all funding committees**, so that the results of the research are not only useful but also valid, especially for those protocols which are not currently mainstream.

C. Be alert to the influence of "gate keeping" upon innovation.

One of the issues for your town meetings has to deal with regulation of CAM providers, and while part of this writer supports a natural desire to ensure minimum qualifications, another part of me shudders at the possible consequences of such gate keeping on the performance of professionals in this area.

As we have a wide spectrum of professionals, so do we have a wide variety of licensing/certification/registration procedures, which serve not only to identify but in many cases to restrict "membership" in the professional field. One of the most tightly regulated professions seems to be that of the medical doctor, who, following graduation, must not only pass rigorous "medical board" exams, but also take periodic refresher courses in medical areas. Perhaps the "least regulated" are artists-- writers, painters, musicians and the like.

Although I've never seen a study of the relationship between "legal permission to practice the profession" versus creativity, my sense of it is portrayed on the coordinates below:



I stress that I've not seen data which support this graphic; it represents my "take" of the correlation based upon 30 years of experience in dealing with the various professions. The reader will have to judge its validity for himself The central point here however is that excessive gate keeping applied to the practice of CAM or any other profession may tend to restrict the innovation which is necessary to keep astride of the health issues which continue to confront our culture, "mad cow disease" being only the very latest in many. Some "certification/degree granting/licensure/registration may be appropriate in order that the purchaser of health care services may identify those who have received training, however excessive legal gate keeping is, in this writer's opinion, not warranted and will tend to be counterproductive as regards the quality of health care.

Grand Summary

There you have it-- the thoughts of a physicist-turned energy worker on some of the

issues with which your commission must deal. In short.....

PROMOTE STABILITY IN HEALTH CARE BY FOSTERING DIVERSITY IN METHODOLOGY AND PHILOSOPHY

PROMOTE GOOD RESEARCH BY UNBIASED RESEARCHERS, WITH FAIR REPRESENTATION ON GRANTING COMMITTEES

AVOID EXCESSIVE GATE KEEPING, LEST IT INHIBIT INNOVATION

Charles Reinert, PhD March 12, 2001

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3 minute testimony for Nancy Hone at the President's Commission on Complementary and Alternative Medicine March 16, 20001 in Minneapolis, Minnesota at the Humphrey Institute on the University of Minnesota Campus. #75

I AM SURE YOU ARE ALL GLAD TO SEE ME. NOT FOR WHAT I HAVE TO SAY, BUT BECAUSE I AM THE LAST ONE TO SPEAK AND YOU CAN ALL GO HOME AND EAT WHEN I AM FINISHED.

My name is Nancy Hone and I am a co-founder of the Minnesota Natural Health Coalition and the Minnesota Natural Health Legal Reform Project.

The other day, Michelle Chang called and said what you really wanted to hear was what we learned from the process of us passing health freedom legislation that can be applied to other states and the federal level and what could make the process easier, better and more equitable.

****

*The #1 thing we learned passing health freedom legislation is that thinking outside the box is good!

*We learned that it is generally accepted in our society that licensure and registration exists to protect the public.

*We learned through research that licensure or registration does not protect the public and in fact gives citizens false confidence.

*We learned that the citizenry was not asking to be protected from something dangerous. They see natural health as non toxic, safe and non invasive. They just want freedom to decide who they go to for their health care.Period. They just care if the practitioners have a track record of helping people.

*We learned through research that licensure and such regulation is always brought by special interest groups to protect their economic base and form a monopoly.

*We learned that you have to tie a natural health care provider to a chair with duct tape to keep them from learning. They are only limited by their time, money and energy. They are very unique this way. They tend to be rabid learners. Requiring education for them is not a problem. They do not have government backed loans and grants for their system of learning. Their schools are not given huge funds by the government yet they eagerly pay out of their pockets.

*We learned that people care about a practitioners training, but care mostly if the practitioner has helped people. They just want the practitioner to tell them how they studied. That's all.

*We learned that these discussions really are about turf battles when it should be about mutual respect and cooperation.

*We learned that the medical establishment puts doubts in legislators heads because of the power and position they hold and the big lobby moneys they have.

*We learned that if you band together as citizens and work hard, you can effect change in the government.

WHAT COULD MAKE THIS PROCESS EASIER, BETTER AND MORE EQUITABLE-

*I refer you to the recommendations of the MNHC and the MNHLRP that were sent to you in advance.

*1. The free wheeling power of the medical, dental and other health boards must be reigned in to make the process easier.

The health boards must be made accountable to the public.

It is not helpful to call us quacks and witches in the legislative arena.

*2. A huge societal shift must happen:
a.)people must take back their power and realize that they must organize and demand changes in the law and pass health freedom laws in every state. Citizens must know they can be successful.

b)Instead of giving $20 million to the NIH for studying St. John's wart when other countries already have, use these funds to educate the American people about how to preserve and promote their health with better health habits. This will make a bigger and better mass mentality so that legislative change is not so hard.

*3.On a state and federal level we must move ahead with great care to ensure that any laws that are passed serve only to protect the very existence of our ancient wisdoms and do not serve to restrict practice of them by anyone through the establishment of educational standards either by law or by professional organizations.

There are many many ways of learning This must be preserved and respected.

*4. Governments must stop trying to protect people from themselves.

FINAL REMARKS:

NATURAL THERAPIES ARE ANCIENT AND SAFE. THEY HAVE BEEN AROUND SINCE THE BEGINNING OF TIME. THIS WISDOM AND THE WRITINGS DOCUMENTING THEM SHOULD BE HELD IN A PLACE OF HONOR, AND RESPECT THAT THEY DESERVE WITH PEOPLE HAVING FREE AND LEGAL ACCESS TO THEM.

THESE ARE NOT NEW UPSTART PROFESSIONS THAT HAVE NOW JUST BEEN DISCOVERED SO THAT THEY NEED TO BE REGULATED WITH EDUCATIONAL STANDARDS TO PROTECT THE PEOPLE OF AMERICA FROM HARM.

How can the process be made more equitable? Give us, the citizens, our freedom. After all this is the United States of America and that is what we stand for--Freedom.

White House Commission on
Complementary and Alternative Medicine Policy
Town Hall Meeting
University of Minnesota
March 16, 2001

Comments of Frank B. Cerra M.D.
Senior Vice President for Health Sciences
University of Minnesota

The Academic Health Center (AHC) has made a major commitment to a Complementary and Alternative Medicine (CAM) program. The driver for this effort came from the health professional students and faculty and the communities that we serve. They all wanted to know what works, what doesn't, how the approach compares to the allopathic, and what the side-effect profiles of the treatments are. The integrated approach to prevention, wellness and therapeutics is now part of the health professional education and training programs, particularly in medicine, nursing and pharmacy. The approach is interdisciplinary and evidence-based.

The research program has also begun. It has received competitive peer reviewed funding from public and private sponsors. The research is basic, translational and outcomes based. The focus on outcomes and the education needs prompted a referral-based clinic to be established. While functioning well, a financial subsidy has been required. The expectation of the people who seek healing there is that their health insurance should cover the services.

I think there are several policy needs that arise from this experience:

1. There should be demonstration projects focused on defining the value of CAM, projects that use defined metrics and have public reporting requirements.
2. Their needs to be more public funding focused on basic, translational and outcomes research in CAM. Expanding the extramural programs of the National Institutes of Health in this area would be an excellent approach.
3. There needs to be accountability in the provision of CAM services. This accountability could take the form of accreditation of education institutions, regulation of the delivery of CAM services, and/or licensing or certification of CAM providers.

CAM holds great potential for promoting health and improving health status, particularly when integrated with the allopathic approach. We need to find where the value is and promote it in the education programs and delivery systems that have responsibility for health status.

Thank you for the opportunity to comment.

White House Commission on Alternative and Complementary Medicine

Minnesota Town Hall Meeting

March 16, 2001

Chris Foley M.D.

Mr. Chairman, distinguished members of the Commission:

I deeply appreciate the opportunity to address the issues before us. Please assume for a moment that the underpinnings of the complementary and alternative medicine movement are not about diverse, unconventional medical modalities but rather that they are grounded in forces such as the deregulation of information, and a cry for freedom and autonomy.

Also assume, if you will, that the transactions of health care goods and services have been crafted into a carefully-designed set of rules, procedure codes, and relative values that are highly specific to the deployment of allopathic medicine. This effectively codifies a "currency" peculiar to our health care system without which any vendor or buyer cannot participate.

This "currency" is further advantaged by its "pretax" leverage, protections granted to it's larger trusts, and the rather restrictive filters through which it must pass in order for it to be usable by those who originally earned it.

There are no pretenses about the need to protect insurance funds, for they indeed require protection from those forces of human nature that would otherwise "fiddle them away" leaving inadequate coverage for the unexpected and catastrophic. But does a separate currency need to be created for the management of a headache, menopause, or high blood pressure? And if it does, should not all modalities be allowed to deal in the same currency? I would submit to you that in the marketplace of ideas, competition is healthy. But this cannot occur when some ideas and approaches are encumbered with a different set of rules and a different "currency". This is a significant barrier to much of what we now know as alternative and complementary medicine.

Leveling this playing field can be done by first, facilitating the development of individualized insurance vehicles such as medical savings accounts, flexible benefit design, and multiple option plans. Tax law needs to be coherent between the states and the federal codes so as to allow these options with a minimum of confusion and maximal consumer awareness. The consumer must enjoy a part of the "pretax dollar leverage" that up until recently was controlled by the insurance company.

Secondly, the procedure and diagnostic codes and current relative value scale used to determine payment must be re-worked to be based on time rather than diagnosis and procedure. We must remove negative incentives that now exist for a physician, chiropractor or other health care professional to spend any time with a patient. We all know that putting an instrument into someone is rewarded more than listening. It is particularly difficult when one cannot find a descriptive diagnostic code that fits an ill-defined condition that has no specific x-ray or blood test to confirm it. For all of the sacred mantras we hear about the "doctor-patient relationship", it seems that the current coding system has done more to destroy it than almost anything else. Somehow time, expertise, and experience must become the major factors in reimbursement of the so-called "evaluation and management codes" rather than how much we did to someone or how neatly their condition fit into a western diagnosis.

It is therefore recommended that this commission

1. **Seed the development of a "common currency" for the consumer such that they enjoy the same pre-tax advantages and choices when seeking alternative care as they do in the allopathic world.**

2. **Move to redefine the procedure and diagnostic coding systems through which health care professionals are paid to reflect time, training, and experience, rather than specific allopathic procedures or diagnoses.**

Written testimony for White House Commission on Complementary and Alternative Medicine Policy

James Woodburn, MD, MS, FACEP
National Account, Medical Director
Blue Cross Blue Shield of Minnesota
March 16, 2001

Dr. Woodburn will be presenting testimony on behalf of Blue Cross and Blue Shield of Minnesota regarding the opportunities and barriers to expanding health plan coverage for Complementary and Alternative Medicine modalities.

Blue Cross has been providing affordable and accessible health plan products for over 65 years in the state of Minnesota. As Blue Cross strives to make a healthy difference in our member's lives, we balance the often conflicting goals of affordability vs. access to health care services. It is with this challenging balancing act that I present to the Commission today, one Health Plan's perspective on Complementary and Alternative Medicine.

The opportunities for health plan members would be greater access and affordability to treatments that are currently unavailable through traditional coverage benefit designs. The benefits of CAM will have been addressed earlier by many speakers during the course of the White House Commission meetings. If research bears out the cost effectiveness and clinical quality improvement benefits of CAM, health plans will begin moving in the direction of providing expanded coverage. It is with sincere hope on the part of Blue Cross and Blue Shield of Minnesota that evidence will soon be available to document the cost-benefit and quality of life improvements that CAM may offer.

The current barriers to expanded health plan coverage for CAM modalities can be summarized by the following observations or perceptions of:

1. Limited purchaser demand for benefit designs that pay for CAM to the same extent that medical care is currently covered;
2. Insufficient rigorously evaluated reports in published, peer-reviewed literature that documents the cost effectiveness for CAM modalities that would lead to a net cost benefit and medical treatment improvements beyond those of current therapies and
3. Uncertainty of the professional and governmental or regulatory oversight for assuring high quality practitioners of CAM modalities such as through licensure or certification that would then be used to build a network of CAM providers for our members.

I would like to reiterate that Blue Cross continues to work hard to balance the affordability of care with benefit designs that our purchasers and members demand. We do this day in and day out and rely on the results of evidence-based judgements and practice.

I would like to conclude my remarks by announcing that Blue Cross and Blue Shield of Minnesota will soon be implementing a partnership with a Complementary and Alternative care network. This will allow our 2 million members to receive a discount on services e.g. acupuncture, massage, herbal supplements as well as traditional health club memberships. We believe that this continues our journey to providing the types of care at the best possible prices that allow our health plan products to be competitive in the Minnesota market and that will meet the needs and expectation of our communities.

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Testimony to the White House Commission on Complementary and Alternative Medicine Policy
Minneapolis, Town Hall Meeting
March 16, 2001

Patricia D. Culliton MA, Lac
Director of Alternative Medicine at Hennepin County Medical Center,
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Good morning, my name is Patricia Culliton. Thank you very much for asking me to address the Commission for a second time. It is an honor to participate. I am the Director of the Alternative Medicine Division at Hennepin Faculty Associates and Hennepin County Medical Center in Minneapolis, Minnesota. I direct a team of 18 non-physician providers of complementary and alternative medicine (CAM) within an academic medical setting. Our staff provides over 25,000 patient visits per year of Chiropractic, massage/bodywork, cranio-sacral therapy, herbal therapy (Chinese, Western and Ayurvedic) and acupuncture. I am a co-founder of the National Acupuncture Detoxification Association and the Society for Acupuncture Research. I have about 20 years in the field of acupuncture service and research, over a decade of CAM management experience, and have worked extensively with insurance carriers regarding reimbursement for acupuncture and other modalities during that time.

Last December in Washington DC, while presenting data on the cost-effectiveness of acupuncture, I made a comment during the question and answer period about the discrepancy of costs vs. reimbursement with some third-party carriers, particularly those that use federal dollars. Today I would like to expand on that concept and restate another issue for your consideration.

You may remember that I mentioned the Medical Assistance reimbursement rate of $17.00 for an acupuncture visit and my concern of establishing an appropriate Medicare reimbursement rate. I also alluded to my fear that there may be a $12.00 reimbursement $50.00 of paperwork costs. That was an embellishment, but the intent of my statement was genuine. At that meeting, Dr. Gordon asked me to submit more information on this topic so I have developed a list of costs associated with providing an acupuncture treatment in a large multi-specialty clinic system.

Based on rather conservative estimates of rent and salary, the cost of an acupuncture visit in this type of setting is between $30.00 and $50.00. Additionally, there are no other billable charges such as procedures or office visits to add to the cost charged to the insurance provider. The acupuncture treatment itself would be the only item billed. As a side note, locally the Medicare reimbursement rate for a chiropractic visit is $29.00. However, chiropractors generally see two to six times more patients per hour than do acupuncturists.

The costs of an acupuncturist in private practice would be less than those listed above, however one would expect an increase in their costs with the handling of insurance forms and the inevitable non-clinical time spent with the consumer.

Many groups including both consumers and providers are lobbying for Medicare coverage of acupuncture. Unless we proceed with caution and a clear understanding of the costs, I have concern that the reimbursement level could be so inadequate that providers would refuse to offer the service. This would cause a reduction of accessibility and would be antithetical to the entire reason for Medicare coverage. Clearly great care must be taken before including acupuncture in the Federal reimbursement policy at an inadequate rate. We do not want to increase the barriers to treatment for the elderly.

Finally, I would like to take some time to elaborate on another issue that I had mentioned previously. Under the banner of access and delivery I ask that you consider the use of acupuncture in public health settings and the potential of student loan forgiveness for those acupuncturists who would work in public health programs. Of course, the use of acupuncture for the treatment of substance abuse is well known and I feel there is great potential in neighborhoods of poverty, including many Native American reservations, for providing cost-effective addictions health care. Other potential areas of service that have data supporting the clinical efficacy of acupuncture are chronic pain, angina, and incontinence. Acupuncturists working off their loans in publicly-funded nursing homes and inpatient programs are likely to have an impact on human suffering as well as decrease health care costs.

Again, I thank you for this opportunity.

Acupuncture Patient Visit Costs

Medical records	Creation of new record	$ 4.00
Clinical staffing	1 hour visits *Acupuncturist $20. per hour plus fringe ($ 27.00) Acupuncturist can see 2 patients per hour	$13.50
	*This rate could double in other areas of US	
Transcription	24 lines @ .23 per line	$ 5.52
Supplies	Acupuncture needles, alcohol swabs, sharps containers, gloves, cotton balls	$ 2.75
Housekeeping/Laundry	gowns, blankets, paper, pillow cases	$ 2.50
Parking	$1.75 per hour (visit = 1 hour)	$ 1.75
Sub total		**$30.02**
Billing/Admin/ Overhead		$ 3.46
Reception staff	with economy of scale	$ 8.33
Rent		$ 4.65
Total		**$46.46**

Sharon Norling, M.D.
University of Minnesota
Center for Spirituality and Healing
612-624-5166

I am the Medical Director of the Mind Body Spirit Clinic, a partnership between the University of Minnesota Academic Health Center and Fairview Health System. As a gynecologist I also provide integrative medicine services at the clinic.

As the Medical Director I have had both opportunity and challenges of (1) negotiating with third party payers, (2) credentialing providers, and (3) integrating CAM healing practices in a conventional academic setting while developing referral patterns.

HMO's, managed care organizations, and health plans have begun to offer limited benefits. For reimbursement they require that the services are safe and effective. They require that the providers are licensed/certified and credentialed. They want medical supervision.

If we are to partner with the patient and health care professionals we must be aware of the barriers and medical legal liability. How does a physician comply with the standard of care within the medical profession while referring to CAM providers or discussing the use of such therapies? What about the physician practicing integrative medicine?

The transformation health care and collaboration with health care professionals necessitate the highest standards. Standard of care creates the minimal level of competence in the selection and delivery of that care. Practitioners who fall below this level of competence risk being held negligent when a patient suffers because of substandard care.

The Federation of State Medical Boards has maintained that "unconventional therapies" should be regulated by applying the prevailing standard of practice.

The Mind Body Spirit Clinic through the Center for Spirituality and Healing has credible and responsible practice, while conducting research and educating health care students. The practices are safe, effective and evidenced based. All providers are certified, licensed and credentialed with Fairview Health System.

It is crucial that patients who are suffering from cancer, pain, and acute and chronic illnesses have these healing therapies available to them.

CONCERNS:

Unregulated models may

(1) Negatively impact our ability to provide integrative medicine.

(2) Reduce reimbursement and access

(3) Increase medical legal risk

RECOMMENDATIONS:

(1) Define standards of care and scope of practice

(2) Certify, license and credential BOTH the physician and non-physician provider of CAM

(3) Mandate health insurers to reimburse safe and effective CAM therapies

If we are to embrace the transformation of health care through holistic integrative medicine we must uphold the highest standards. This will ensure public safety, minimize medical legal risk and increase reimbursement and access.

Most importantly, it will offer the best of both worlds to our patients, individuals, and communities.

Woodwinds
Health Campus

White House Commission on Complementary and Alternative Medicine

Testimony from

Julie Schmidt, CEO
Woodwinds Health Campus

Minnesota Town Hall Meeting
March 16, 2001

Julie Schmidt Testimony
White House Commission on Complementary and Alternative Medicine
Minnesota Town Hall Meeting
March 16, 2001

Members of the White House Commission on Complementary and Alternative Medicine....Thank you for giving me an opportunity to speak briefly at this Minnesota Town Hall Meeting. I am the CEO at Woodwinds Health Campus in Woodbury, Minnesota.

I have provided you with a more lengthy testimony and background information on the Woodwinds Health Campus. The Woodwinds story is one I think you'll find to be a wonderful example of what health care can be in the future. I hope that we will have the opportunity to give you a tour of the facility on a future occasion.

In the interests of honoring your schedule, I will make but a few key points:

My first point - Complementary and Alternative Medicine is growing in popularity because of consumer demand. It's a trend we saw emerging five years ago during the design phase of our hospital project. Members of our "Design Team,"(community residents and staff members chosen for their innovative thinking), conducted community forums and surveys with hundreds of area residents. One of the overwhelming messages was that consumers didn't like the fact that traditional western medicine and complementary medicine were so distant from one another and they wanted them integrated in their future vision of health care.

Because our goal was to design a health care delivery model that would better meet the needs of our community, our Design Team created a set of Guiding Principles, one of which was: *"Foster choice by providing a spectrum of care with integration of select complementary approaches to health and well being."*

The second point – Bringing this principle to life required collaboration among several parties. HealthEast Care System, Children's Hospitals and Clinics and Woodwinds partnered with Northwestern Health Sciences University and the University of Minnesota Center for Spirituality and Healing to address the community request to offer an Integrative approach to care. The result is a proactive effort to link traditional and complementary medicine on the campus on several fronts. The Natural Care Center at Woodwinds (a joint venture of Woodwinds and Northwestern Health Sciences University) offers chiropractic, acupuncture, massage therapy, naturopathy and a certified Master Herbalist. It took two years of relationship building to make this Care Center a reality. It's all about people and understanding. A key to successful integration is the role of our Integrative Health Services Leader, who is a holistic nurse. Her responsibilities include staff, physician and community education, coordination of services from the Natural Care Center to the inpatient and outpatient areas of the hospital, and identification of research opportunities. Accomplishing true integration as opposed to peaceful co-existence will be a long journey; but we have made important progress in just a few months' time.

The third point – Today, our work involves primarily a limited number of complementary modalities. As the body of scientific evidence grows to demonstrate effectiveness of other modalities, we will add those to the array of treatments available on the Woodwinds campus. At a federal level, the work of the National Institutes of Health in research of complementary medicine is an important ingredient. We encourage you to advocate continued research as an important part of the federal public policy agenda.

My fourth point – Education of doctors and other practitioners on complementary and alternative modalities is critical to successful integration in the future. Assuring that the curriculum for these training programs includes this chapter of learning is imperative. The reverse is also true – complementary and alternative medicine practitioners need to know enough about western treatment modalities to be able to make referrals where appropriate.

The fifth point – How people pay for these services over time is an important consideration. The traditional approach is to build the case to simply add new services, drugs or treatment modalities to the existing insurance benefits. Consumers have demonstrated a willingness to pay for these treatments for the most part. We would encourage you to consider other means of making access to these services possible for those who need the help through personal tax credits or other mechanisms that keep more control in the hands of the consumer.

And, my final point – There is simply not enough information for consumers today on the interaction of "all natural" vitamins and

supplements with pharmaceutical medications or their affect on existing health conditions. Labeling of these products or other means of disclosure are important policy considerations.

Again, thank you for giving me time to speak with you today. We look forward to working with all who advocate the continued pursuit of providing health care consumers a wide variety of appropriate approaches to healing.