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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	welcome to WHCCAMP's Minneapolis town hall (partial) (1 page)	03/16/2001	b(6)

COLLECTION:
Federal Records
White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43233

FOLDER TITLE:
Town Meeting, Minnesota [March 16, 2001] [3]

2011-0568-S
kc846

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Sheet
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[001]

White House Commission on Complementary and Alternative Medicine Policy

Minneapolis Town Hall
Hubert H. Humphrey Institute, Cowles Auditorium
March 16, 2001
8:00 a.m. – 6:00 p.m.

Dear Commissioner:

Welcome to Minneapolis! Please find attached briefing materials for your review and use. In addition to the agenda and submitted comments/testimony, we have compiled background information regarding the Minnesota Statute 146A. As many of the comments on Friday may relate to that legislation, you may find the information helpful to review in advance.

WHERE TO BE, WHEN:

Thursday, March 15: Welcoming Reception at the home of Bill and Penny George (b)(6) Minneapolis
5:30 p.m. – 7:30 p.m.

We have rented a mini-van and will depart from the lobby of the Holiday Inn Metrodome, 1500 Washington Avenue South at 5:00 p.m. promptly. Please meet us in the main lobby by 4:45 p.m.

Friday, March 16: The Town Hall begins promptly at 8:00 a.m. There may be very light refreshments available at the site for breaks, however, we recommend that you breakfast on your own. Lunch will also be on your own at one of the two cafeteria-restaurants available at the meeting site.

We will leave from the main lobby of the hotel promptly at 7:30 a.m. The Town Hall will be held at the **Hubert H. Humphrey Institute, Cowles Auditorium, 301 19th Avenue, South** on the University of Minnesota Campus.

Please note that the meeting is scheduled from 8:00 a.m. – 6:00 p.m. With 75 speakers, the agenda is EXTREMELY full, so please keep your questions brief and limit yourself to one or two per panel. We MUST vacate the facility by 6:15 p.m.

Enjoy the reading and I look forward to seeing you very soon!

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.

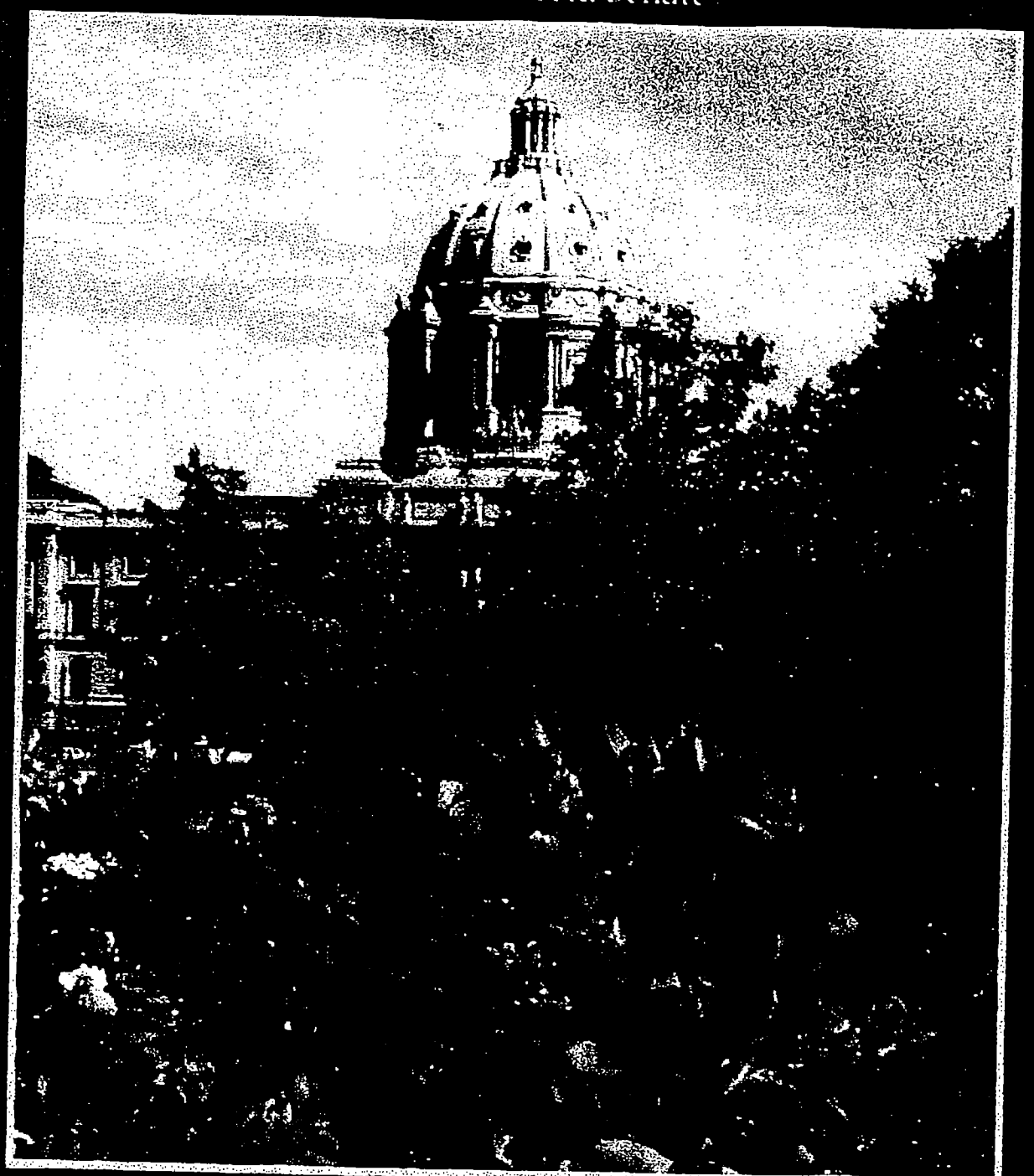
Commissioner's Briefing Book

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

Contents:

Perspectives

A Publication about the Minnesota Senate



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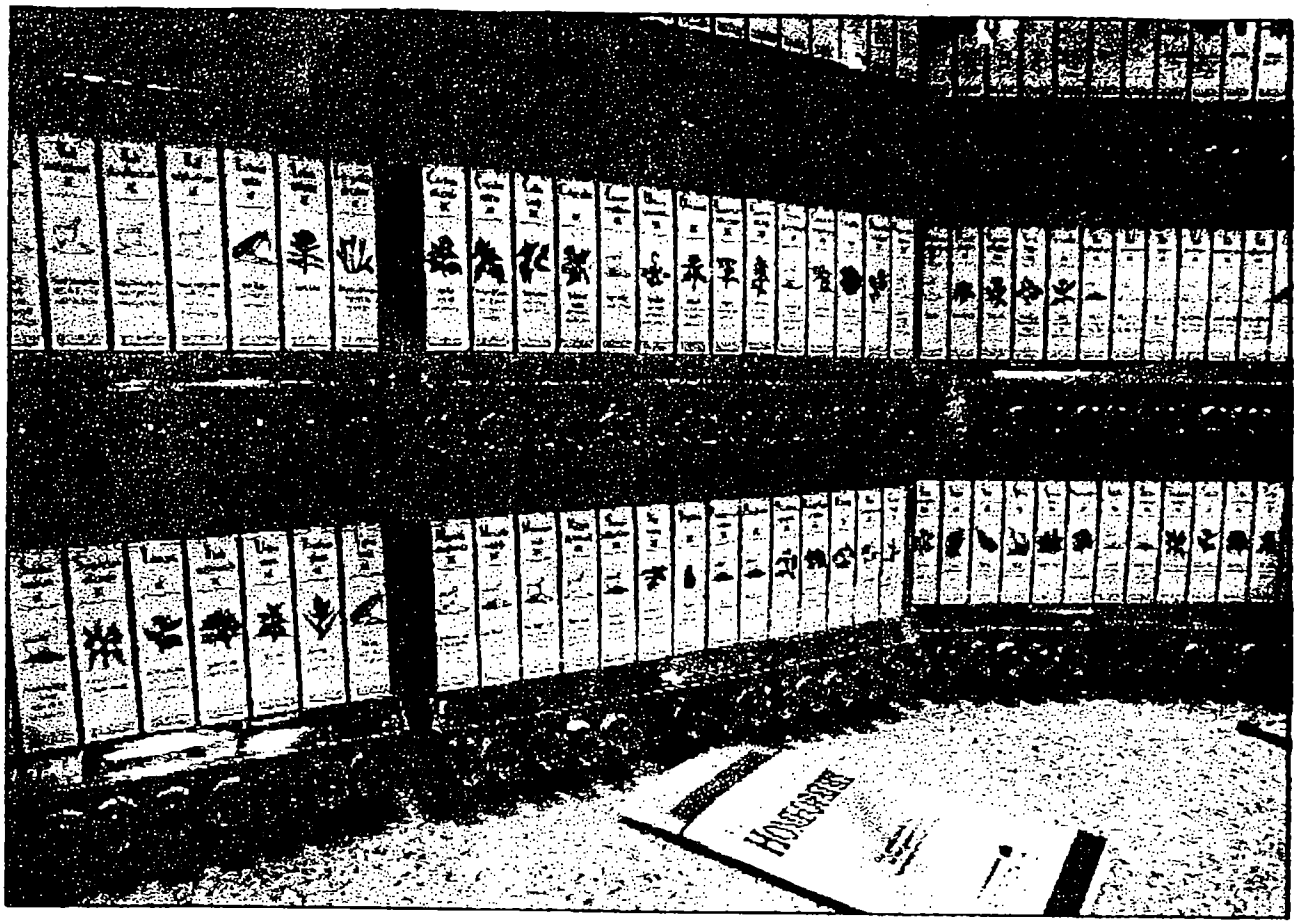


Photo by Andrea Gordon Murrill

Alternative and complementary care:

Striking a balance between consumer choice and consumer protection

by Christopher Cullen

In a right-hand drawer of the stately wooden desk in room G-9 of the Capitol, Sen. Twyla Ring (DFL-North Branch) keeps an overstuffed manilla folder labeled "Consumer Driven" ready for quick procurement. The folder contains more than 80 letters in support of S.F. 689, the Complementary and Alternative Health Care Freedom of Access Act. The bill is unique for a freshman Senator. "Usually freshman senators get departmental and agency bills, all of which easily pass," said Ring. "For this bill, I needed to polish up my marketing skills and try to address people's concerns." The bill establishes the Office of Unlicensed Complementary and Alternative Health Care Practice in the Department of Health (DOH) to both serve as a clearing house for information on practices and practitioners and to take action against complementary and alternative health care practitioners for violations of rules against prohibited conduct.

Statistics from the National Institutes of Health (NIH) show that 40 percent of United States citizens used some form of complementary or alternative medicine in 1997, exceeding $21.2 billion in total spending. According to a study conducted by the DOH in 1998, Minnesota alone is home to about 3,000 complementary and alternative health care workers. Despite the prolific usage of practices listed in the bill, such as anthroposophy, ayurveda, cranial sacral therapy, Gerson therapy, non-diagnostic iridology, and Qi Gong energy healing, many people are unfamiliar with them. The practices range from ancient traditions to a closely watched diet. Ayurveda, originating in India more than 5,000 years ago, encourages attention to balance in one's life, right thinking, diet and the use of herbs. Anthroposophy is a path of knowledge to guide the spiritual in the human being to the spiritual in the universe. Cranial Sacral Therapy uses gentle movements to unlock tension and relieve pain. Gerson therapy combines an organic diet with coffee enemas. Qi Gong refers to a group of exercises that improve health and longevity. Less esoteric practices such as acupressure, aroma therapy, homeopathy, and massage therapy are also included in the bill.

When describing complementary and alternative care, Sen. Michelle Fischbach (R-Paynesville), a co-author of the bill, explains that it is "not necessarily the kind of treatment that you think of when people say medical

care; it's not the mainstream medical care that an M.D. offers." The bill states that surgery, X-rays, using controlled substances, dispensing drugs, puncturing the skin, setting fractures, and using medical devices do not qualify as complementary and alternative medicine.

Under the bill, the Office of Unlicensed Complementary and Alternative Health Care Practice is to investigate complaints and take action against complementary and alternative health care practitioners for violations of prohibited conduct rules. Violations defined in the bill include not obtaining informed consent from clients, false advertising, showing a willful disregard for a patient's health, having sexual relations with a client, and being mentally incompetent. The office has the authority to impose a civil penalty of up to $10,000 and the authority to revoke the privilege to practice. "These powers are very critical in light of the widespread usage of such practices," said Ring.

"This issue has been around for quite a number of years," said Sen. Don Samuelson (DFL-Brainerd), when speaking of his motivation for co-authoring the bill. "More and more people are choosing alternative practices, and those in the medical profession, including physicians, are showing support for them as well." Samuelson mentioned that traditional medical establishments have begun to incorporate complementary practices into their programs. The Alternative Medicine Clinic of Hennepin County, the recently established Center for Spirituality and Healing at the University of Minnesota, Twin Cities, and curricula at the University of Minnesota, Duluth, the University of Texas, Houston, and Stanford are a few examples. Samuelson echoed Ring and said that as these practices become more widely used, "we need governmental oversight. This new office in the DOH, with investigative and disciplinary powers all the way to civil action, will provide that."

In Paynesville, where Fischbach lives, a complementary and alterative heath care clinic recently opened. The complementary clinic, directed by a medical doctor from a conventional clinic, features chiropractic and natural medicine. "Some medical doctors are willing to embrace and see value in complementary practices," she said. Fischbach views the services offered by the second clinic as a new voice to accompany traditional health care. "It says, 'let's treat the whole person and make the whole person healthy.'" She added, "I have never met an alternative care provider who did not say that there is a place for medical doctors. What regular doctors offer is much different than what one would find in a complementary clinic." Fischbach stresses that there is a need for conventional medicine, but "as I see it, they can all work together."

Fischbach said that for her, supporting the bill is an issue of letting people seek the kind of care that they want. She is a frequent patron of chiropractors, whose legitimacy was once heavily questioned. "I see a chiropractor at least once a month for back trouble," she said. "A regular medical doctor gave me muscle relaxers to combat discomfort, but should I be on a muscle relaxer every time I have back pain?" She said that, whereas muscle relaxers cause her to feel drowsy and slightly inattentive, chiropractic work eases back pain without compromising her mental or physical faculties.

Fischbach also talked about a homeopathic medication she used to effectively treat skin irritation caused by a watch. Conventional medications did not assuage the metal-induced irritation, she said. However, a co-worker of her husband gave Fischbach a green homeopathic paste in a small bottle. "It worked," she said. She compared the homeopathic remedy to now-common vitamins and garlic supplements. "A few years ago, what would people have thought?" she asked.

Having an affinity for traditional practices, which Fischbach said many of the complementary and alternative practices are, drew her to the bill as well. Previously Fischbach co-authored a bill clarifying licensure requirements for the traditional practice of midwifery. "It is only in modern times that midwives

Sen. Twyla Ring

Photo by David J. Oakes

Sen. Michelle Fischbach

have not been accepted," she said. "Years ago midwifery was the only way to have a child, and I see a parallel between midwifery and many of these practices."

"I lived in China for six months in 1997 while teaching English," said Ring when recalling an event that exposed her to traditional remedies. "Because I was the toast of the party, which you always are as the foreign expert, I was presented with a little glass of something red to drink which nobody else received. I knew this meant either that the drink was expensive, or that it was a very prestigious and high honor. The liquid tasted like seawater and turned out to be turtle blood. It was a real high honor, but I had a real stomach problem after that. I went through the medicine drawer of the American teacher's apartment and used all the Kaopectate and Pepto Bismol there was, but I did not feel any better. My mentor went off to the school nurse and returned with a little thing to chew that had an intense herbal medicine taste, and an hour later I felt better.

"I thought my recovery could have come about between the combination of the Kaopectate and the herbal nugget. Then I had a control test when I was given a glass of red liquid at a different party. I thought this was just purely coincidental, so down the hatch it went. It was turtle blood again, and I went home not feeling very well at all. I took one of the herbal nuggets and felt better in very little time. We consider these practices nontraditional in the United States, but in other parts of the world they are very traditional."

The bill that the freshman Senator chose to cut her teeth on has an extensive history. On Feb. 11, 1999, former Sen. Steven Morse (DFL-Dakota) introduced S.F. 689 on the Senate floor. The first draft, modeled after statutes regulating unlicensed mental health workers, established protections and a right to practice for complementary and alternative health care workers under the DOH's authority. The bill's first draft did not allow civil action to be brought against an unlicensed complementary or alterative health care provider unless informed consent was not obtained from the patient or the treatment caused the patient harm. Also, criminal charges for practicing medicine without a license could not be brought against complementary and alternative health care practitioners. The bill was referred to the Health and Family Security Committee, where it remained through three authors.

The late Sen. Janet Johnson became the bill's author on Mar. 11, 1999, after Morse resigned from the Senate to become an assistant commissioner in the Department of Natural Resources. Concerns about state legitimization of unregulated practices and conflicts with the Board of Medical Practice prevented the bill from leaving the committee. That year Johnson was diagnosed with brain cancer in late June, and passed away in August.

With a long history of public service that includes school board and local government positions, Twyla Ring came to the Senate after a special election on Nov. 2, 1999. "I was encouraged to run for office by Janet Johnson's family and good friends," she said. Ring and Johnson, long time friends, were "on the same page philosophically, so I promised that if I was elected, I would continue Janet's work."

What was introduced on Feb. 11, 1999, and what Governor Jesse Ventura signed into law on May 4, 2000, differ considerably. Critics of the original bill voiced concerns about consumer protection. Because the original bill established a narrow list of situations allowing a client to seek damages, the medical community raised strong concerns about what effects the protections for complementary and alternative care practitioners in the original bill would have on patients. Whereas licensed medical professionals receive six or more years of education to develop an understanding of the human body, practitioners without state-regulated education would receive state protection. The final legislation focuses on consumer protection while allowing complementary and alternative care practitioners to continue their services in Minnesota.

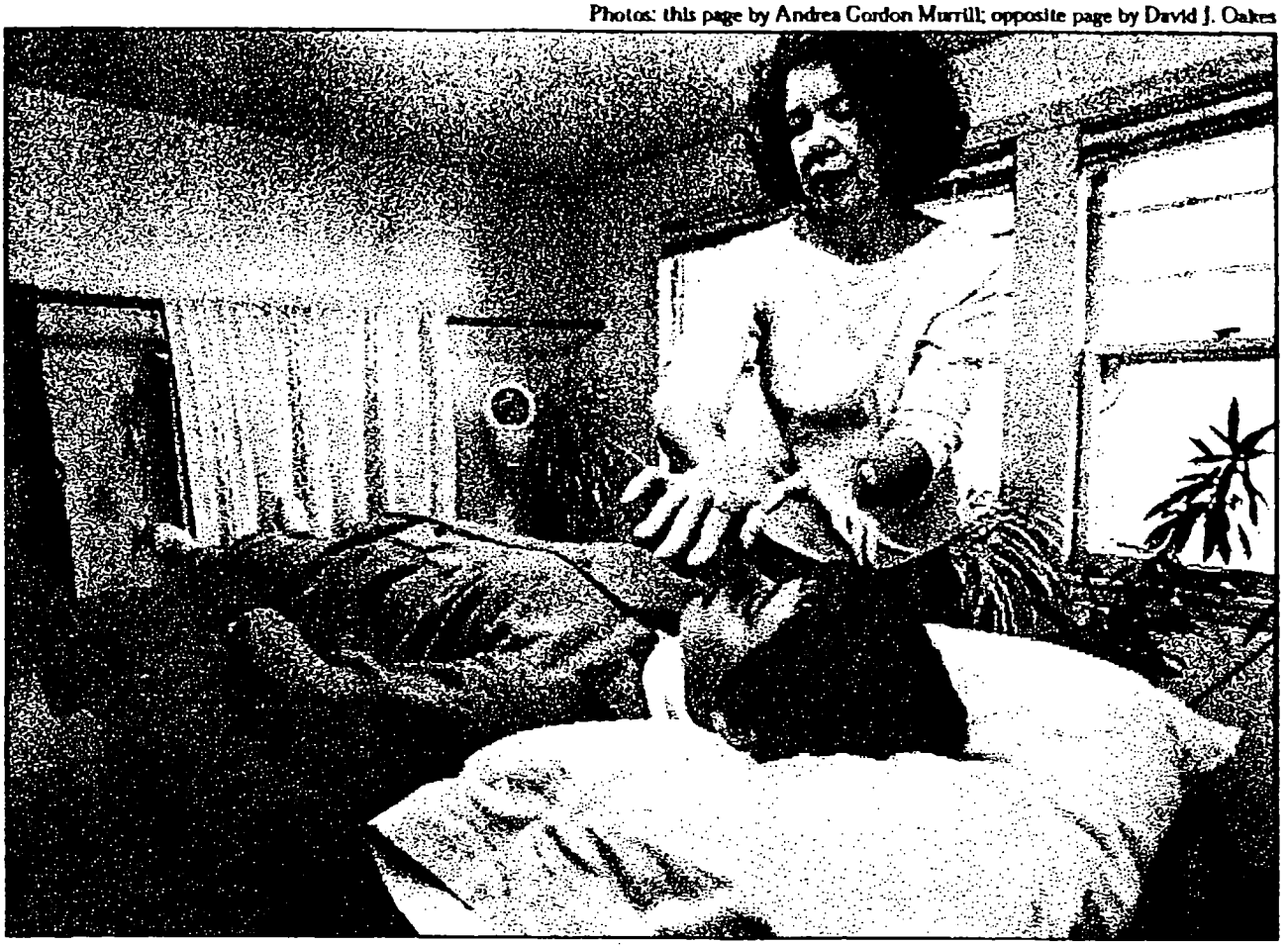
"I could not support the original bill," said Sen. Sheila Kiscaden (R-Rochester). However, Kiscaden placed Ring's revised legislation in H.F. 3839, a bill Kiscaden authored modifying provisions for speech-language pathologists, audiologists, unlicensed mental health practitioners, and hearing aid dispensers.

Reaching the compromise that was adopted by the conference com-mittee was a laborious process. "I thought I was going to hit the ground running when first taking office," Ring said, "but the system is complicated; I was overwhelmed. Now I am just starting to figure out how all of this works, and it is really quite fascinating."

Ring threw the original legislation out and placed the idea of complementary and alterative health care on the table for discussion. "[The idea] was

Sen. Don Samuelson

Photos: this page by Andrea Gordon Murrill; opposite page by David J. Oakes



A client receives a therapy session from Jeanne Martin Cherner, a Qi Gong energy healing practitioner.

indeed chewed up and spit out on both sides [of the Legislature], and now we have a stronger bill that even the medical community is comfortable with," said Ring. After hearings in the Judiciary Committee, the Governmental Operations and Veterans Committee, eight hours of debate in the House's Civil Law Committee, two hearings in the Health and Family Security Committee, debate on the floor of both legislative bodies, and conversations with the DOH, the Board of Medical Practice, and the Alliance of Natural Health, an agreement was reached.

Currently, people with concerns about complementary and alternative practices are advised to call the Board of Medical Practice. When the legislation takes effect this year, not only will clients of complementary and alternative health care practitioners be presented with a disclosure form explaining their rights and the qualifications of the practitioner, but they will also have a formal process at their disposal to investigate infringements of those rights. The disclosure statement to clients must include: "THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY."

On a fiscal note prepared for the bill, the DOH projected 275 calls to the Office of Unlicensed Complementary and Alternative Care annually, "which I thought was a little heavy," said Ring. Robert Leech, executive director of the Board of Medical Practice, said that in the past 12 years, the board has documented only 10 calls pertaining to complementary and alternative health care workers. Of those calls, Leech said, the majority were from people who felt that a loved one was engaging in something strange.

Having no predecessor to the newly created office, DOH analysts based the number of projected calls on those concerning unlicensed mental health workers. Because massage therapists compose roughly two thirds of the complementary health care practitioners in the state, Ring surmises that a substantial amount of the calls placed to the office will relate to suspected prostitution fronts, rather than the violations under her bill. These conjectures will be tested when the DOH, as mandated by the legislation, reports back to the Legislature on Jan. 1, 2003. The report must detail the number of calls it received, the progress of any complementary and alternative health care related cases in court, the success of those cases, and their cost.

Both Kiscaden and Ring lauded the bicameral structure of the Legislature for bringing an improved bill to fruition. Kiscaden said the result is "really indicative of a bill that shows the strong points of a bicameral system." "The Senate and House, with their different

Sen. Allan Spear

Photos by David J. Oakes

committee make-ups, different outlooks, and different amendments, picked up on different things," Ring said. With good reason, Ring believes that the bipartisan cooperation that crafted the bill would not have taken place in a unicameral system. Not only does Ring cite the extra number of committees as a positive influence of the bicameral structure, but she also said that power is distributed more evenly between political parties. "In a unicameral structure we would end up with a one party system," she said. Currently, the Senate holds a Democratic majority and the House holds a Republican majority. With this division of influence, both parties have ample opportunity to discuss a bill.

"This bill provides a comfort level for consumers," Ring said. Because Minnesota is one of the first states to have such legislation, Ring said that potential frauds will likely relocate outside of the state. Ring calls the measure "consumer protection with freedom of access." She said, "We do not need a lot of government intervention, but we do need some kind of oversight to protect the public."

"This bill also allows practitioners to practice complementary and alternative health care without fear of practicing medicine without a license," said Ring. In order to satisfy concerns from the Board of Medical Practice and other medical organizations, the Legislature excluded complementary and alternative practitioners from the jurisdiction of the body in the DOH that oversees conventional medical practitioners. Ring said that the new Office of Unlicensed Complementary and Alternative Health Care has no relation to other established health boards, which retain complete jurisdiction over their own practitioners.

"What I am trying to do with this bill is address people's fears of the quacksters," Ring said. "I liken this legislation to a situation where I am a robber going down the street to steal a car. Am I going to stop at the car with a "Club" on the steering wheel and an alarm that turns the lights on when you touch the door? No, I am going to go to an easier take." She explained that the formal complaint and investigation process in the bill offers protection to those seeking complementary and alternative care by providing a deterrent to potential fraudulent practitioners. "With this bill the quacksters are going to fly so fast out of this state to some state without these protections, that they will leave a trail of feathers."

Ring said that as of now, people have very little objective information about complementary and alternative health care practices. "With this legislation," she said, "the Department of Health will have a clearing house of information for consumers." Nevertheless, she said, there are no significant reports to date of consumers being wronged by alternative care practitioners.

Whereas proponents of the bill view the measure as a tool for ridding Minnesota of quacks and providing consumers with a choice in health care, Sen. Allan Spear (DFL-Mpls.) sees the same legislation as giving questionable practices a state sanctioned legitimacy. "What I generally object to in the bill," Spear said, "though it is not specifically a licensing bill, is that the measure does at least implicitly put a state imprimatur on medical practices that, to put it kindly, are of unproven benefit." Spear said that by establishing a formal process to oversee misuse of complementary and alternative practices, the state implies that a legitimacy to the practices exists. "We are basically saying that if people go to these quacks and they have some grievance, then the state of Minnesota is going to provide some mechanism for dealing with that as though this was a legitimate thing to do in the first place," said Spear.

What is most frightening to Spear is the list of practices covered by the bill. "Some of them are just pure quackery" he said. Spear cites a few of the practices listed in the bill as having proven efficacy, such as acupressure and massage therapy, but holds reservations for practices like anthroposophy and ayurveda. Spear argues that the bill is a springboard for further requests from complementary and alternative medicine practitioners to expand the list of acceptable practices. "There are people advocating for this bill saying that this is modest, this is not licensing, we are not specifically authorizing them or setting up a scope of practice, but I would suggest that once you pass this bill, [further requests] are going to be coming next. I have watched this happen with

chiropractics." Although chiropractors were licensed before Spear took office, since that time requests have been made every year by chiropractors to the Legislature for privileges such as third party payments, inclusion in HMOs, an expanded scope of practice, and the authority to draw blood.

"I am not suggesting that we will be having aroma therapists performing brain surgery within the next couple of years, but I will suggest that within the next couple of years you are going to see people coming in asking for third party payments and wanting to be covered by insurance policies." Kiscaden said that complementary and alternative health care practitioners are opposed to having minimum competency requirements, a criterion for receiving third party payments.

Supporters of the bill argue that because of the widespread use of complementary and alternative practices, some form of consumer protection should be offered. Unlike the bulging folder containing letters of support for the measure, Ring says that she does not have anything comparable in opposition. "I received a lot more letters on this than I did on the Profile of Learning, and they were so one sided," she said. Whereas Samuelson said that he has not received prominent constituent response about the issue, he added that "if people were opposed, I certainly would have heard from them."

"Many people explained in their letters that if all they were doing was extending dying instead of extending living [with conventional medical practices], then they wanted to try something else," said Ring. Ring said that a number of people she knows have used alternative treatments for cancer and been satisfied with the results. "I have people call me who are cured. It is not government's job to say you cannot choose that. Opposition to this bill did not come from people, it came from doctors and the medical institutions." The measure explicitly states that complementary and alternative practitioners are not allowed to make a medical diagnosis, she said, "that's where 'complementary' comes in."

Spear expressed a different sentiment. "I believe that some of the greatest progress that has been made in the world over the last couple of hundred years has been made in the field of medical science. It has come through the scientific method, which involves testing and experimentation. It seems to me, that at a point when we have so many kinds of scientific medical practices that our grandparents and great-grandparents would not have even dreamed of, including drugs, remedies, and diagnostic tools, that to be encouraging people to go to a bunch of alternative care practitioners is not what we as the Legislature ought to be doing."

"I know that one of the arguments is that people are going to be doing it anyway," Spear said, "but that does not mean that because people are doing it that we should be saying that essentially the state approves of them. I would rather have the state, instead of setting up this board, become involved in educational efforts to discourage people from going to these healers. I do not want to put people in jail for going to them, and I do generally believe that adults have the right to do anything they want to with their own bodies, no matter how foolish. However, at the same time, I don't particularly want the state to encourage these practices.

Samuelson and Kiscaden agree that some legitimization of questionable medical practices may result from the establishment of a governmental body to administer a complaint process, but both agree that the benefits of consumer protection validate the state's recognition of the practices. However, other supporters of the bill said that the measure is simply a needed response to a field that is already legitimized. Ring questioned the government's role to legitimize practices that, according to a study by Allina Health Systems, two thirds of Minnesota families already use. "The government does not have to legitimize these practices," she said. "What the government has to do is secure for people informed consent to participate in these practices, mandate fee notification, explain what constitutes fraud, and provide someone people can go to if they feel they have been defrauded. As of now, they don't know where to go."

Sen. Sheila Kiscaden

In Fischbach's view, what legitimization may take place will be the result of practitioners whose efficacy is proven because they are not affected by the legislation. She said that the bill provides protection from the obvious hoaxes, giving the example of healers who claim to pull tumors bloodlessly from a stomach. Concerning other practices, she said "If we legitimize them, so we are legitimizing them. What is not legitimate about helping people take vitamins and offering them relief from their ills in a more natural way? We are not licensing nor registering complementary practitioners." Fischbach agrees that consumer protection outweighs any of the arguments about legitimation.

"I feel very comfortable with the bill," Ring said. She added that not only is the Board of Medical Practice no longer in opposition to the legislation, but the Board of Chiropractic Care and the Board of Holistic Nurses are also in support of the measure. With the measure honed, Ring is excited for its implementation, and ready to accept all responses. "Let's get this off the ground, let it run for a couple of years and see what happens. If this legislation ends up to be a huge problem in the state of Minnesota, I will be the first one to introduce legislation to say no, forget it, but I do not think that is going to happen."

"Right now there is no disclosure to consumers at all," Ring said. "This bill gives people an opportunity to see a written document that says the state does not license or certify these practices, describes the provider's area of expertise and how he or she is purported to achieve that, explains what constitutes fraud and harm, and provides instructions for how and where to complain about services."

SUMMARY of MINNESOTA STATUTE 146A COMPLEMENTARY AND ALTERNATIVE HEALTHCARE FREEDOM OF ACCESS ACT

9/27/2000

146A.01 Definitions: Explains what Complementary and Alternative Health Care Practices ARE, what they are NOT, and who is an Unlicensed Complementary and Alternative Health Care Practitioner.

146A.02 Creates the Office of Unlicensed Complementary and Alternative Health Care Practice within the Minnesota Department of Health to investigate complaints and enforce disciplinary actions against practitioners for violations of prohibited conduct.

146A.025 Assures that existing laws regarding maltreatment of minors is followed.

146A.03 Establishes a duty to report violations to the Office of Unlicensed Complementary and Alternative Health Care. Includes self-reporting.

146A.04 States conditions for immunity from liability for reporting violations of this chapter.

146A.05 States the data privacy status of disciplinary records for Court in the event of Judicial Review:

146A.06 Sets out the obligation of an Unlicensed Complementary and Alternative Health Care Practitioner to cooperate with an investigation by the Office of Unlicensed Complementary and Alternative Health Care. Establishes data status of client, complainant, and investigative records

146A.07 States the Office's obligation to investigate and keep a file of complaints.

146A.08 Spells out 24 areas of prohibited conduct for Unlicensed Complementary and Alternative Health Care practitioners.

146A.09 Lists the actions that the Department of Health can take against practitioners when the Commissioner finds that a practitioner has violated a provision of this chapter.

146A.10 Gives additional remedies, including cease and desist orders and injunctive relief.

146A.11 States what must be included in the Complementary and Alternative Health Care Client Bill of Rights.

147.09(15) Amends MN Stat. 147.09 and exempts unlicensed complementary health care practitioners from the Board of Medical Practice Statute if they are practicing according to this statute

214.01 Sub 2 Amends MN Stat. 214.01 to include the office of unlicensed complementary and alternative health care practice in the definition of what is a health-related licensing board.

Section 65: Section 65 of Chapter 460 Session Laws requires Dept. of Health to collect data and report back to the legislature on the complaints received and actions taken under this chapter.

Section 67. Section 67 of Chapter 460 Session Laws states the effective Date of 147A to be July 1, 2001.

Prepared by Attorney Diane Miller. 1398 25th St. N.W. New Brighton. MN 55112

MINNESOTA CHAPTER 146A

COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTICES

146A.01 Definitions.

Subdivision 1. Terms. As used in this chapter, the following terms have the meanings given them.

Subd. 2. Commissioner. "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 3. Complementary and alternative health care client. "Complementary and alternative health care client" means an individual who receives services from an unlicensed complementary and alternative health care practitioner.

Subd. 4. Complementary and alternative health care practices. (a) "Complementary and alternative health care practices" means the broad domain of complementary and alternative healing methods and treatments, including but not limited to: (1) acupressure; (2) anthroposophy; (3) aroma therapy; (4) ayurveda; (5) cranial sacral therapy; (6) culturally traditional healing practices; (7) detoxification practices and therapies; (8) energetic healing; (9) polarity therapy; (10) folk practices; (11) healing practices utilizing food, food supplements, nutrients, and the physical forces of heat, cold, water, touch, and light; (12) Gerson therapy and colostrum therapy; (13) healing touch; (14) herbology or herbalism; (15) homeopathy; (16) nondiagnostic iridology; (17) body work, massage, and massage therapy; (18) meditation; (19) mind-body healing practices; (20) naturopathy; (21) noninvasive instrumentalities; and (22) traditional Oriental practices, such as Qi Gong energy healing.

(b) Complementary and alternative health care practices do not include surgery, x-ray radiation, administering or dispensing legend drugs and controlled substances, practices that invade the human body by puncture of the skin, setting fractures, the use of medical devices as defined in section 147A.01, any practice included in the practice of dentistry as defined in section 150A.05, subdivision 1, or the manipulation or adjustment of articulations of joints or the spine as described in section 146.23 or 148.01.

(c) Complementary and alternative health care practices do not include practices that are permitted under section 147.09,

clause (11), or 148.271, clause (5).

(d) This chapter does not apply to, control, prevent, or restrict the practice, service, or activity of lawfully marketing or distributing food products, including dietary supplements as defined in the federal Dietary Supplement Health and Education Act, educating customers about such products, or explaining the uses of such products. Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments.

Subd. 5. Office of unlicensed complementary and alternative health care practice or office. "Office of unlicensed complementary and alternative health care practice" or "office" means the office of unlicensed complementary and alternative health care practice established in section 146A.02.

Subd. 6. Unlicensed complementary and alternative health care practitioner. (a) "Unlicensed complementary and alternative health care practitioner" means a person who:

(1) either: (i) is not licensed or registered by a health-related licensing board or the commissioner of health; or

(ii) is licensed or registered by the commissioner of health or a health-related licensing board other than the board of medical practice, the board of dentistry, the board of chiropractic examiners, or the board of podiatric medicine, but does not hold oneself out to the public as being licensed or registered by the commissioner or a health-related licensing board when engaging in complementary and alternative health care;

(2) has not had a license or registration issued by a health-related licensing board or the commissioner of health revoked or has not been disciplined in any manner at any time in the past, unless the right to engage in complementary and alternative health care practices has been established by order of the commissioner of health;

(3) is engaging in complementary and alternative health care practices; and

(4) is providing complementary and alternative health care services for remuneration or is holding oneself out to the public as a practitioner of complementary and alternative health care practices.

(b) A health care practitioner licensed or registered by the commissioner or a health-related licensing board, who engages in complementary and alternative health care while practicing under the practitioner's license or registration, shall be regulated by and be under the jurisdiction of the applicable health-related licensing board with regard to the complementary and alternative health care practices.

HIST: 2000 c 460 s 9

146A.02 Office of unlicensed complementary and alternative health care practice.

Subdivision 1. Creation. The office of unlicensed complementary and alternative health care practice is created in the department of health to investigate complaints and take and enforce disciplinary actions against all unlicensed complementary and alternative health care practitioners for violations of prohibited conduct, as defined in section 146A.08. The office shall also serve as a clearinghouse on complementary and alternative health care practices and unlicensed complementary and alternative health care practitioners through the dissemination of objective information to consumers and through the development and performance of public education activities, including outreach, regarding the provision of complementary and alternative health care practices and unlicensed complementary and alternative health care practitioners who provide these services.

Subd. 2. Rulemaking. The commissioner shall adopt rules necessary to implement, administer, or enforce provisions of this chapter pursuant to chapter 14.

HIST: 2000 c 460 s 10

146A.025 Maltreatment of minors.

Nothing in this chapter shall restrict the ability of a local welfare agency, local law enforcement agency, the commissioner of human services, or the state to take action regarding the maltreatment of minors under section 609.378 or 626.556. A parent who obtains complementary and alternative health care for the parent's minor child is not relieved of the duty to seek necessary medical care consistent with the requirements of sections 609.378 and 626.556. A complementary or alternative health care practitioner who is providing services to a child who is not receiving necessary medical care must make a report under section 626.556. A complementary or

alternative health care provider is a mandated reporter under section 626.556, subdivision 3.

HIST: 2000 c 460 s 11

146A.03 Reporting obligations.

Subdivision 1. Permission to report. A person who has knowledge of any conduct constituting grounds for disciplinary action relating to complementary and alternative health care practices under this chapter may report the violation to the office.

Subd. 2. Institutions. A state agency, political subdivision, agency of a local unit of government, private agency, hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the office any action taken by the agency, institution, or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition an unlicensed complementary and alternative health care practitioner's privilege to practice or treat complementary and alternative health care clients in the institution or, as part of the organization, any denial of privileges or any other disciplinary action for conduct that might constitute grounds for disciplinary action by the office under this chapter. The institution, organization, or governmental entity shall also report the resignation of any unlicensed complementary and alternative health care practitioners prior to the conclusion of any disciplinary action proceeding for conduct that might constitute grounds for disciplinary action under this chapter or prior to the commencement of formal charges but after the practitioner had knowledge that formal charges were contemplated or were being prepared.

Subd. 3. Professional societies. A state or local professional society for unlicensed complementary and alternative health care practitioners shall report to the office any termination, revocation, or suspension of membership or any other disciplinary action taken against an unlicensed complementary and alternative health care practitioner. If the society has received a complaint that might be grounds for discipline under this chapter against a member on which it has not taken any disciplinary action, the society shall report the complaint and the reason why it has not taken action on it or shall direct the complainant to the office.

Subd. 4. Licensed professionals. A licensed health professional shall report to the office personal knowledge of any conduct that the licensed health professional reasonably believes constitutes grounds for disciplinary action under this chapter by any unlicensed complementary and alternative health care practitioner, including conduct indicating that the individual may be incompetent or may be mentally or physically unable to engage safely in the provision of services. If the information was obtained in the course of a client relationship, the client is an unlicensed complementary and alternative health care practitioner, and the treating individual successfully counsels the other practitioner to limit or withdraw from practice to the extent required by the impairment, the office may deem this limitation of or withdrawal from practice to be sufficient disciplinary action.

Subd. 5. Insurers. Four times each year as prescribed by the commissioner, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to unlicensed complementary and alternative health care practitioners or the medical joint underwriting association under chapter 62F shall submit to the office a report concerning the unlicensed complementary and alternative health care practitioners against whom malpractice settlements or awards have been made. The response must contain at least the following information:

(1) the total number of malpractice settlements or awards made;

(2) the date the malpractice settlements or awards were made;

(3) the allegations contained in the claim or complaint leading to the settlements or awards made;

(4) the dollar amount of each malpractice settlement or award;

(5) the regular address of the practice of the unlicensed complementary and alternative health care practitioner against whom an award was made or with whom a settlement was made; and

(6) the name of the unlicensed complementary and alternative health care practitioner against whom an award was made or with whom a settlement was made.

The insurance company shall, in addition to the above information, submit to the office any information, records, and files, including clients' charts and records, it possesses that tend to substantiate a charge that an unlicensed complementary and alternative health care practitioner may have engaged in conduct violating this chapter.

Subd. 6. Courts. The court administrator of district court or any other court of competent jurisdiction shall report to the office any judgment or other determination of the court that adjudges or includes a finding that an unlicensed complementary and alternative health care practitioner is mentally ill, mentally incompetent, guilty of a felony, guilty of a violation of federal or state narcotics laws or controlled substances act, or guilty of abuse or fraud under Medicare or Medicaid; or that appoints a guardian of the unlicensed complementary and alternative health care practitioner under sections 525.54 to 525.61 or commits an unlicensed complementary and alternative health care practitioner under chapter 253B.

Subd. 7. Self-reporting. An unlicensed complementary and alternative health care practitioner shall report to the office any personal action that would require that a report be filed with the office by any person, health care facility, business, or organization pursuant to subdivisions 2 to 5. The practitioner shall also report the revocation, suspension, restriction, limitation, or other disciplinary action against the practitioner's license, certificate, registration, or right of practice in another state or jurisdiction for offenses that would be subject to disciplinary action in this state and also report the filing of charges regarding the practitioner's license, certificate, registration, or right of practice in another state or jurisdiction.

Subd. 8. Deadlines; forms. Reports required by subdivisions 2 to 7 must be submitted not later than 30 days after the reporter learns of the occurrence of the reportable event or transaction. The office may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to ensure prompt and accurate reporting.

HIST: 2000 c 460 s 12

146A.04 Immunity.

Subdivision 1. Reporting. Any person, other than the unlicensed complementary and alternative health care

practitioner who committed the violation, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting a report to the office, for otherwise reporting to the office violations or alleged violations of this chapter, or for cooperating with an investigation of a report, except as provided in this subdivision. Any person who knowingly or recklessly makes a false report is liable in a civil suit for any damages suffered by the person or persons so reported and for any punitive damages set by the court or jury. An action requires clear and convincing evidence that the defendant made the statement with knowledge of falsity or with reckless disregard for its truth or falsity. The report or statement or any statement made in cooperation with an investigation or as part of a disciplinary proceeding is privileged except in an action brought under this subdivision.

Subd. 2. Investigation. The commissioner and employees of the department of health and other persons engaged in the investigation of violations and in the preparation, presentation, and management of and testimony pertaining to charges of violations of this chapter are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

HIST: 2000 c 460 s 13

146A.05 Disciplinary record on judicial review.

Upon judicial review of any disciplinary action taken by the commissioner under this chapter, the reviewing court shall seal the portions of the administrative record that contain data on a complementary and alternative health care client or a complainant under section 146A.03, and shall not make those portions of the administrative record available to the public.

HIST: 2000 c 460 s 14

146A.06 Professional cooperation; unlicensed practitioner.

Subdivision 1. Cooperation. An unlicensed complementary and alternative health care practitioner who is the subject of an investigation, or who is questioned in connection with an investigation, by or on behalf of the office, shall cooperate fully with the investigation. Cooperation includes responding

fully and promptly to any question raised by or on behalf of the office relating to the subject of the investigation, whether tape recorded or not; providing copies of client records, as reasonably requested by the office, to assist the office in its investigation; and appearing at conferences or hearings scheduled by the commissioner. If the office does not have a written consent from a client permitting access to the client's records, the unlicensed complementary and alternative health care practitioner shall delete in the record any data that identifies the client before providing it to the office. If an unlicensed complementary and alternative health care practitioner refuses to give testimony or produce any documents, books, records, or correspondence on the basis of the fifth amendment to the Constitution of the United States, the commissioner may compel the unlicensed complementary and alternative health care practitioner to provide the testimony or information; however, the testimony or evidence may not be used against the practitioner in any criminal proceeding. Challenges to requests of the office may be brought before the appropriate agency or court.

Subd. 2. Data.

(a) Data relating to investigations of complaints and disciplinary actions involving unlicensed complementary and alternative health care practitioners are governed by this subdivision and section 13.41 does not apply. Except as provided in section 13.39, subdivision 2, and paragraph (b), data relating to investigations of complaints and disciplinary actions involving unlicensed complementary and alternative health care practitioners are public data, regardless of the outcome of any investigation, action, or proceeding.

(b) The following data are private data on individuals, as defined in section 13.02:

(1) data on a complementary and alternative health care client;

(2) data on a complainant under section 146A.03; and

(3) data on the nature or content of unsubstantiated complaints when the information is not maintained in anticipation of legal action.

Subd. 3. Exchanging information. (a) The office shall establish internal operating procedures for:

(1) exchanging information with state boards; agencies, including the office of ombudsman for mental health and mental retardation; health-related and law enforcement facilities; departments responsible for licensing health-related occupations, facilities, and programs; and law enforcement personnel in this and other states; and

(2) coordinating investigations involving matters within the jurisdiction of more than one regulatory agency.

(b) The procedures for exchanging information must provide for the forwarding to the entities described in paragraph (a), clause (1), of information and evidence, including the results of investigations, that are relevant to matters within the regulatory jurisdiction of the organizations in paragraph (a). The data have the same classification in the hands of the agency receiving the data as they have in the hands of the agency providing the data.

(c) The office shall establish procedures for exchanging information with other states regarding disciplinary action against unlicensed complementary and alternative health care practitioners.

(d) The office shall forward to another governmental agency any complaints received by the office that do not relate to the office's jurisdiction but that relate to matters within the jurisdiction of the other governmental agency. The agency to which a complaint is forwarded shall advise the office of the disposition of the complaint. A complaint or other information received by another governmental agency relating to a statute or rule that the office is empowered to enforce must be forwarded to the office to be processed in accordance with this section.

(e) The office shall furnish to a person who made a complaint a description of the actions of the office relating to the complaint.

HIST: 2000 c 460 s 15

146A.07 Professional accountability.

The office shall maintain and keep current a file containing the reports and complaints filed against unlicensed complementary and alternative health care practitioners within the commissioner's jurisdiction. Each complaint filed with the office must be investigated. If the files maintained by the

office show that a malpractice settlement or award has been made against an unlicensed complementary and alternative health care practitioner, as reported by insurers under section 146A.03, subdivision 5, the commissioner may authorize a review of the practitioner's practice by the staff of the office.

HIST: 2000 c 460 s 16

146A.08 Prohibited conduct.

Subdivision 1. Prohibited conduct. The commissioner may impose disciplinary action as described in section 146A.09 against any unlicensed complementary and alternative health care practitioner. The following conduct is prohibited and is grounds for disciplinary action:

(a) Conviction of a crime, including a finding or verdict of guilt, an admission of guilt, or a no-contest plea, in any court in Minnesota or any other jurisdiction in the United States, reasonably related to engaging in complementary and alternative health care practices. Conviction, as used in this subdivision, includes a conviction of an offense which, if committed in this state, would be deemed a felony, gross misdemeanor, or misdemeanor, without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is made or returned but the adjudication of guilt is either withheld or not entered.

(b) Conviction of any crime against a person. For purposes of this chapter, a crime against a person means violations of the following: sections 609.185; 609.19; 609.195; 609.20; 609.205; 609.21; 609.215; 609.221; 609.222; 609.223; 609.224; 609.2242; 609.23; 609.231; 609.2325; 609.233; 609.2335; 609.235; 609.24; 609.245; 609.25; 609.255; 609.26, subdivision 1, clause (1) or (2); 609.265; 609.342; 609.343; 609.344; 609.345; 609.365; 609.498, subdivision 1; 609.50, subdivision 1, clause (1); 609.561; 609.562; 609.595; and 609.72, subdivision 3.

(c) Failure to comply with the self-reporting requirements of section 146A.03, subdivision 7.

(d) Engaging in sexual contact with a complementary and alternative health care client or former client, engaging in contact that may be reasonably interpreted by a client as sexual, engaging in any verbal behavior that is seductive or sexually demeaning to the patient, or engaging in sexual exploitation of a client or former client. For purposes of this paragraph, "former client" means a person who has obtained

services from the unlicensed complementary and alternative health care practitioner within the past two years.

(e) Advertising that is false, fraudulent, deceptive, or misleading.

(f) Conduct likely to deceive, defraud, or harm the public or demonstrating a willful or careless disregard for the health, welfare, or safety of a complementary and alternative health care client; or any other practice that may create danger to any client's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(g) Adjudication as mentally incompetent or as a person who is dangerous to self or adjudication pursuant to chapter 253B as chemically dependent, mentally ill, mentally retarded, mentally ill and dangerous to the public, or as a sexual psychopathic personality or sexually dangerous person.

(h) Inability to engage in complementary and alternative health care practices with reasonable safety to complementary and alternative health care clients.

(i) The habitual overindulgence in the use of or the dependence on intoxicating liquors.

(j) Improper or unauthorized personal or other use of any legend drugs as defined in chapter 151, any chemicals as defined in chapter 151, or any controlled substance as defined in chapter 152.

(k) Revealing a communication from, or relating to, a complementary and alternative health care client except when otherwise required or permitted by law.

(l) Failure to comply with a complementary and alternative health care client's request made under section 144.335 or to furnish a complementary and alternative health care client record or report required by law.

(m) Splitting fees or promising to pay a portion of a fee to any other professional other than for services rendered by the other professional to the complementary and alternative health care client.

(n) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

(o) Failure to make reports as required by section 146A.03 or cooperate with an investigation of the office.

(p) Obtaining money, property, or services from a complementary and alternative health care client, other than reasonable fees for services provided to the client, through the use of undue influence, harassment, duress, deception, or fraud.

(q) Undertaking or continuing a professional relationship with a complementary and alternative health care client in which the objectivity of the unlicensed complementary and alternative health care practitioner would be impaired.

(r) Failure to provide a complementary and alternative health care client with a copy of the client bill of rights or violation of any provision of the client bill of rights.

(s) Violating any order issued by the commissioner.

(t) Failure to comply with any provision of sections 146A.01 to 146A.11 and the rules adopted under those sections.

(u) Failure to comply with any additional disciplinary grounds established by the commissioner by rule.

(v) Revocation, suspension, restriction, limitation, or other disciplinary action against any health care license, certificate, registration, or right to practice of the unlicensed complementary and alternative health care practitioner in this or another state or jurisdiction for offenses that would be subject to disciplinary action in this state or failure to report to the office that charges regarding the practitioner's license, certificate, registration, or right of practice have been brought in this or another state or jurisdiction.

(w) Use of the title "doctor," "Dr.," or "physician" alone or in combination with any other words, letters, or insignia to describe the complementary and alternative health care practices the practitioner provides.

(x) Failure to provide a complementary and alternative health care client with a recommendation that the client see a health care provider who is licensed or registered by a health-related licensing board or the commissioner of health, if there is a reasonable likelihood that the client needs to be seen by a licensed or registered health care provider.

Subd. 2. Less customary approach. The fact that a complementary and alternative health care practice may be a less customary approach to health care shall not constitute the basis of a disciplinary action per se.

Subd. 3. Evidence. In disciplinary actions alleging a violation of subdivision 1, paragraph (a), (b), (c), or (g), a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same is admissible into evidence without further authentication and constitutes prima facie evidence of its contents.

Subd. 4. Examination; access to medical data. (a) If the commissioner has probable cause to believe that an unlicensed complementary and alternative health care practitioner has engaged in conduct prohibited by subdivision 1, paragraph (g), (h), (i), or (j), the commissioner may issue an order directing the practitioner to submit to a mental or physical examination or chemical dependency evaluation. For the purpose of this subdivision, every unlicensed complementary and alternative health care practitioner is deemed to have consented to submit to a mental or physical examination or chemical dependency evaluation when ordered to do so in writing by the commissioner and further to have waived all objections to the admissibility of the testimony or examination reports of the health care provider performing the examination or evaluation on the grounds that the same constitute a privileged communication. Failure of an unlicensed complementary and alternative health care practitioner to submit to an examination or evaluation when ordered, unless the failure was due to circumstances beyond the practitioner's control, constitutes an admission that the unlicensed complementary and alternative health care practitioner violated subdivision 1, paragraph (g), (h), (i), or (j), based on the factual specifications in the examination or evaluation order and may result in a default and final disciplinary order being entered after a contested case hearing. An unlicensed complementary and alternative health care practitioner affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the practitioner can resume the provision of complementary and alternative health care practices with reasonable safety to clients. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the commissioner shall be used against an unlicensed complementary and alternative health care practitioner in any other proceeding.

(b) In addition to ordering a physical or mental examination or chemical dependency evaluation, the commissioner

may, notwithstanding section 13.42; 144.651; 595.02; or any other law limiting access to medical or other health data, obtain medical data and health records relating to an unlicensed complementary and alternative health care practitioner without the practitioner's consent if the commissioner has probable cause to believe that a practitioner has engaged in conduct prohibited by subdivision 1, paragraph (g), (h), (i), or (j). The medical data may be requested from a provider as defined in section 144.335, subdivision 1, paragraph (b), an insurance company, or a government agency, including the department of human services. A provider, insurance company, or government agency shall comply with any written request of the commissioner under this subdivision and is not liable in any action for damages for releasing the data requested by the commissioner if the data are released pursuant to a written request under this subdivision, unless the information is false and the person or organization giving the information knew or had reason to believe the information was false. Information obtained under this subdivision is private data under section 13.41.

HIST: 2000 c 460 s 17

146A.09 Disciplinary actions.

Subdivision 1. Forms of disciplinary action. When the commissioner finds that an unlicensed complementary and alternative health care practitioner has violated any provision of this chapter, the commissioner may take one or more of the following actions, only against the individual practitioner:

(1) revoke the right to practice;

(2) suspend the right to practice;

(3) impose limitations or conditions on the practitioner's provision of complementary and alternative health care practices, impose rehabilitation requirements, or require practice under supervision;

(4) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the practitioner of any economic advantage gained by reason of the violation charged or to reimburse the office for all costs of the investigation and proceeding;

(5) censure or reprimand the practitioner;

(6) impose a fee on the practitioner to reimburse the

office for all or part of the cost of the proceedings resulting in disciplinary action including, but not limited to, the amount paid by the office for services from the office of administrative hearings, attorney fees, court reports, witnesses, reproduction of records, staff time, and expense incurred by the staff of the office of unlicensed complementary and alternative health care practice; or

(7) any other action justified by the case.

Subd. 2. Discovery; subpoenas. In all matters relating to the lawful activities of the office, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. Any person failing or refusing to appear or testify regarding any matter about which the person may be lawfully questioned or failing to produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the commissioner or by a subpoena of the commissioner to do so may, upon application to the district court in any district, be ordered to comply with the order or subpoena. The commissioner may administer oaths to witnesses or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process may be served upon a person it names anywhere within the state by any officer authorized to serve subpoenas or other process in civil actions in the same manner as prescribed by law for service of process issued out of the district court of this state.

Subd. 3. Hearings. If the commissioner proposes to take action against the practitioner as described in subdivision 1, the commissioner must first notify the practitioner against whom the action is proposed to be taken and provide the practitioner with an opportunity to request a hearing under the contested case provisions of chapter 14. If the practitioner does not request a hearing by notifying the commissioner within 30 days after service of the notice of the proposed action, the commissioner may proceed with the action without a hearing.

Subd. 4. Reinstatement. The commissioner may at the commissioner's discretion reinstate the right to practice and may impose any disciplinary measure listed under subdivision 1.

Subd. 5. Temporary suspension. In addition to any other remedy provided by law, the commissioner may, acting through a

person to whom the commissioner has delegated this authority and without a hearing, temporarily suspend the right of an unlicensed complementary and alternative health care practitioner to practice if the commissioner's delegate finds that the practitioner has violated a statute or rule that the commissioner is empowered to enforce and continued practice by the practitioner would create a serious risk of harm to others. The suspension is in effect upon service of a written order on the practitioner specifying the statute or rule violated. The order remains in effect until the commissioner issues a final order in the matter after a hearing or upon agreement between the commissioner and the practitioner. Service of the order is effective if the order is served on the practitioner or counsel of record personally or by first class mail. Within ten days of service of the order, the commissioner shall hold a hearing on the sole issue of whether there is a reasonable basis to continue, modify, or lift the suspension. Evidence presented by the office or practitioner shall be in affidavit form only. The practitioner or the counsel of record may appear for oral argument. Within five working days after the hearing, the commissioner shall issue the commissioner's order and, if the suspension is continued, schedule a contested case hearing within 45 days after issuance of the order. The administrative law judge shall issue a report within 30 days after closing of the contested case hearing record. The commissioner shall issue a final order within 30 days after receipt of that report.

Subd. 6. Automatic suspension. The right of an unlicensed complementary and alternative health care practitioner to practice is automatically suspended if (1) a guardian of an unlicensed complementary and alternative health care practitioner is appointed by order of a court under sections 525.54 to 525.61, or (2) the practitioner is committed by order of a court pursuant to chapter 253B. The right to practice remains suspended until the practitioner is restored to capacity by a court and, upon petition by the practitioner, the suspension is terminated by the commissioner after a hearing or upon agreement between the commissioner and the practitioner.

Subd. 7. Licensed or regulated practitioners. If a practitioner investigated under this section is licensed or registered by the commissioner of health or a health-related licensing board, is subject to the jurisdiction of the commissioner under section 146A.01, subdivision 6, paragraph (a), clause (1), item (ii), and the commissioner determines that the practitioner has violated any provision of this chapter, the commissioner, in addition to taking disciplinary action under

this section:

(1) may, if the practitioner is licensed or regulated in another capacity by the commissioner, take further disciplinary action against the practitioner in that capacity; or

(2) shall, if the practitioner is licensed or registered in another capacity by a health-related licensing board, report the commissioner's findings under this section, and may make a nonbinding recommendation that the board take further action against the practitioner in that capacity.

HIST: 2000 c 460 s 18

146A.10 Additional remedies.

Subdivision 1. Cease and desist. (a) The commissioner may issue a cease and desist order to stop a person from violating or threatening to violate a statute, rule, or order which the office has issued or is empowered to enforce. The cease and desist order must state the reason for its issuance and give notice of the person's right to request a hearing under sections 14.57 to 14.62. If, within 15 days of service of the order, the subject of the order fails to request a hearing in writing, the order is the final order of the commissioner and is not reviewable by a court or agency.

(b) A hearing must be initiated by the office not later than 30 days from the date of the office's receipt of a written hearing request. Within 30 days of receipt of the administrative law judge's report, the commissioner shall issue a final order modifying, vacating, or making permanent the cease and desist order as the facts require. The final order remains in effect until modified or vacated by the commissioner.

(c) When a request for a stay accompanies a timely hearing request, the commissioner may, in the commissioner's discretion, grant the stay. If the commissioner does not grant a requested stay, the commissioner shall refer the request to the office of administrative hearings within three working days of receipt of the request. Within ten days after receiving the request from the commissioner, an administrative law judge shall issue a recommendation to grant or deny the stay. The commissioner shall grant or deny the stay within five days of receiving the administrative law judge's recommendation.

(d) In the event of noncompliance with a cease and desist order, the commissioner may institute a proceeding in Hennepin

county district court to obtain injunctive relief or other appropriate relief, including a civil penalty payable to the office not exceeding $10,000 for each separate violation.

Subd. 2. Injunctive relief. In addition to any other remedy provided by law, including the issuance of a cease and desist order under subdivision 1, the commissioner may in the commissioner's own name bring an action in Hennepin county district court for injunctive relief to restrain an unlicensed complementary and alternative health care practitioner from a violation or threatened violation of any statute, rule, or order which the commissioner is empowered to regulate, enforce, or issue. A temporary restraining order must be granted in the proceeding if continued activity by a practitioner would create a serious risk of harm to others. The commissioner need not show irreparable harm.

Subd. 3. Additional powers. The issuance of a cease and desist order or injunctive relief granted under this section does not relieve a practitioner from criminal prosecution by a competent authority or from disciplinary action by the commissioner.

HIST: 2000 c 460 s 19

146A.11 Complementary and alternative health care client bill of rights.

Subdivision 1. Scope. All unlicensed complementary and alternative health care practitioners shall provide to each complementary and alternative health care client prior to providing treatment a written copy of the complementary and alternative health care client bill of rights. A copy must also be posted in a prominent location in the office of the unlicensed complementary and alternative health care practitioner. Reasonable accommodations shall be made for those clients who cannot read or who have communication impairments and those who do not read or speak English. The complementary and alternative health care client bill of rights shall include the following:

(1) the name, complementary and alternative health care title, business address, and telephone number of the unlicensed complementary and alternative health care practitioner;

(2) the degrees, training, experience, or other qualifications of the practitioner regarding the complimentary and alternative health care being provided, followed by the

following statement in bold print:

"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.";

(3) the name, business address, and telephone number of the practitioner's supervisor, if any;

(4) notice that a complementary and alternative health care client has the right to file a complaint with the practitioner's supervisor, if any, and the procedure for filing complaints;

(5) the name, address, and telephone number of the office of unlicensed complementary and alternative health care practice and notice that a client may file complaints with the office;

(6) the practitioner's fees per unit of service, the practitioner's method of billing for such fees, the names of any insurance companies that have agreed to reimburse the practitioner, or health maintenance organizations with whom the practitioner contracts to provide service, whether the practitioner accepts Medicare, medical assistance, or general assistance medical care, and whether the practitioner is willing to accept partial payment, or to waive payment, and in what circumstances;

(7) a statement that the client has a right to reasonable notice of changes in services or charges;

(8) a brief summary, in plain language, of the theoretical approach used by the practitioner in providing services to clients;

(9) notice that the client has a right to complete and current information concerning the practitioner's assessment and

recommended service that is to be provided, including the expected duration of the service to be provided;

(10) a statement that clients may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner;

(11) a statement that client records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law;

(12) a statement of the client's right to be allowed access to records and written information from records in accordance with section 144.335;

(13) a statement that other services may be available in the community, including where information concerning services is available;

(14) a statement that the client has the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs;

(15) a statement that the client has a right to coordinated transfer when there will be a change in the provider of services;

(16) a statement that the client may refuse services or treatment, unless otherwise provided by law; and

(17) a statement that the client may assert the client's rights without retaliation.

Subd. 2. Acknowledgment by client. Prior to the provision of any service, a complementary and alternative health care client must sign a written statement attesting that the client has received the complementary and alternative health care client bill of rights.

HIST: 2000 c 460 s 20

* NOTE: This section, as added by Laws 2000, chapter 460, *section 20, is effective July 1, 2001. Laws 2000, chapter 460, *section 67.

Agenda
&
Speakers' Comments and Testimony

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, VP :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. 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

4:20 p.m. – 4:55 p.m. 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

4:55 p.m. – 5:25 p.m. 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

5:25 p.m. – 6:00 p.m. 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, ND: Santulan Health Center
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

6:00 p.m.* ADJOURNED

* 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

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

1. Frank Bernard Cerra, MD
University of Minnesota

2. Chris Foley, MD
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

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

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

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.

8:55 – 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. Timothy P. Culbert, MD
Children's Hospitals and Clinics

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:
-- "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

9:35 – 10:15 a.m. <u>Dietary Supplements</u>

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

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

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. Education of CAM Providers

17. Margery A. Wells
Diplomate in Oriental Medicine, American Association of Oriental Medicine, Health Source

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)
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. <u>Education of Health Professionals</u>

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.

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)

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.

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
St. Olaf College

NOTES:
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. 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

34. Okokon Udo
Director: Center for Cross-Cultural Health

12:30 – 1:30 p.m. LUNCH BREAK

1:30 – 2:10 p.m. 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.

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. 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.
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. Minnesota Legislation

47. Diane Miller, JD
National Health Freedom Coalition

(Background materials and talking points attached next page)

Additional Testimony Points

Diane M. Miller JD
Executive Director of National Health Freedom Coalition:
Providing legal information and resources for decision-makers involved in reform for complementary and alternative health care.
Defense Counsel for complementary and alternative practitioners and healers
Drafter and Lobbyist for MN Model

Additional Points to Keep in Mind Regarding Credentialing and Government Regulation in addition to testimony already before you:

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

   There are 1000s of unlicensed healers, permeated throughout the culture, many in solo practice without affiliation to national groups, with a broad array of backgrounds and talents, many of whom use a combination of skills to assist consumers.

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

   There are 1000s of licensed healers across all professions utilizing a broad range of healing arts, specific to their own personal interests, having gotten their information from many sources, and utilizing it to assist patients.

3. **Educational credentials or degrees are not the same as government delegated titles and regulation.** There are 1000 of groups that promote educational credentials and accreditation of schools and degrees. Many of these groups also support the practice of their profession by non-degreed individuals. Example, Northwestern School of Homeopathy.

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

   If regulation is necessary for harmful practices, then the use of least restrictive regulation is important to avoid using scope of practice laws that promote turf battles. Jurisdiction statutes rather than scope of practice statutes work better to avoid this problem

4. **Consumer expectations are based on the location and culture in which they find themselves.** That is the beauty of culture. Pluralism is an important component of a strong society. Free expression of rituals and traditions make for a rich culture. Federal homogeneity should be reserved only for those situations that pose an imminent risk of harm to the country as a whole, to a community or to an individual. Uniformity around safety should always be balanced with free expression of a culture.

Addition Recommendations (in addition to the attached document of Finding and Recommendations of the National Health Freedom Coalition):

1. Reform laws so that unlicensed healers and practitioners are not charged criminally for practicing their trade or art. Charge only when a practitioner has broken other regular criminal laws already in place. Consumer have the right to access all healers and all healers should have an legal avenue of accessibility to consumers.

2. Reform laws so that licensed practitioners and healers always have legal avenues in which they can practice healing practices outside of the prevailing standard of care. Consumers have the right to access all licensed practitioners practicing outside of their prevailing and accepted standard of care and all practitioners should have a legal avenue of accessibility to consumers.

3. Adopt public policy that promotes:

   a. education and innovation without leaving individuals or groups that do not participate in that education in legal jeopardy and inaccessible to consumers.
   b. the use of all healing behaviors across all occupational disciplines whenever possible. When that is not possible due to imminent risk of harm then adopt public policy that promotes extensive collaborative models of delivery and promote cooperation between groups.
   c. adopt public policy in health that demands a consumer informed environment in all health related circumstances. The Client Bill of Rights in MN is an example of a great tool to disseminate information to consumers as well as providing a way for written information to make its way between a host of other practitioners.

4. United States citizens should always allocate the burden of proof to the government for any restriction on their choices of healing treatments or practitioners. The legal standard of imminent risk of harm to consumers is a proper standard for government oversight.

5. For review of National Health Freedom Coalition Findings and Recommendations please see attached document.

FINDINGS AND RECOMMENDATIONS FOR COMPLEMENTARY AND ALTERNATIVE HEALTH CARE REGULATION

Produced by

National Health Freedom Coalition

The National Health Freedom Coalition finds that:

1. Every individual has the basic right of self-determination and the right to make their own personal choices in the process of healing. Each individual person is ultimately responsible for securing their own health and well being and making decisions to that end.

2. In order to have the right of self-determination, in the fullest sense of the word, every person has a constitutional right of access to any healing or health care practitioner, 'reatment, or information source they desire. This right remains, whether or not treatment options are generally accepted, well known, recognized, or researched, and regardless of a practitioner's education, training, and experience.

3. There is a broad range of types of health care practitioners and healing modalities and treatments available, be they conventional or nonnconventional, holistic, integrative, natural, or culturally specific, and many of these have provided people with profound healing effects. The individual has the ultimate responsibility for assessing whether a particular treatment or practitioner has been or is likely to be beneficial to them in their healing process.

4. Studies indicate that consumers are placing increased reliance on nonconventional healthcare providers and healing modalities to avoid the excessive cost of conventional medical services and to obtain more holistic consideration of their needs.

5. The role of the government in healthcare is to protect citizens from harm, and at the same time to protect citizen rights to individual choice and autonomy.

6. The basic right of self-determination dictates that regulations are not to be imposed that impact consumer individual rights unless they are clearly required for the safety and well being of citizens. If regulations are imposed, the following criteria should be used: 1) necessity to protect the safety and well being of citizens, and 2) use of the least restrictive means of regulation possible.

7. The least-restrictive means of regulation, balancing the role of the government to protect individuals from harm with the role of the government to protect individual autonomy and choice, should be founded on principles of a consumer informed environment and clear avenues of consumer recourse for complaints.

8. Consumers benefit from, and deserve to have, truthful information in order to make informed choices regarding their healthcare. For example, a consumer benefits when a practitioner is required, before treatment begins, to give disclosure to the consumer regarding the method of healthcare they provide and their training and experience in the health care they practice.

9. Consumers benefit from having accessible places to direct their complaints and deserve to be supported in their expectation of receiving ethical treatment and truthful information. For example, if a person has been harmed or put in the position of imminent risk of direct harm by a modality or a practitioner relationship, the government should have in place a mechanism for consumer complaint and clear grounds for disciplinary actions to correct the situation.

Re: State Occupational Regulation

10. The use of state licensure, registration, and certification to regulate health care occupations is not the least restrictive means of regulation and can negatively impact consumer options when used as the sole means of regulation. In fact, licensure is the most restrictive type of regulation, utilizing the broadest sweep of police power possible for occupations. Licensure laws typically describe an area of practice, demand particular types of education and training and use of exclusive titles for that practice, demand that the practitioner stay within the prevailing standard of care of the education and training mandated by the government for that practice, and then exclude all other persons from practicing in that area of healing.

11. Consumers are disempowered by states that only use the most restrictive means of regulation and do not provide an additional form of regulation that protects consumer options. Health-care regulations that are exclusive, that bestow ultimate power on particular types of professional and delivery systems to the exclusion of others, and that limit available healing practitioners and treatments through enforcement of exclusive and restrictive occupational laws, decrease consumer options in health care and infringe on the individual's basic right of self-determination to make choices.

12. Consumers are empowered by states that use additional least-restrictive means regulations that ensure all practitioners the right to practice and the right to use the full range of treatment methods. These states maximize consumer choice and protect the right of self-determination of the individual to make informed decisions about their health and acknowledge and respect consumer needs for meaningful information and reasonable practitioner/client relationship expectations.

13. There are recognized problems that occur when a state attempts to use exclusive and restrictive occupational regulation for nonconventional, holistic, integrative, natural or culturally specific types of healing practices:

a. Education: Government-mandated educational standards for the multidisciplinary and the broad domain of healing arts can be misleading and unrealistic and can decrease consumer access to practitioners that do not abide by governments' mandates. Attempts

to regulate may involve setting arbitrary numbers of classroom hours at selected types of educational institutions with the receipt of conventional types of degrees, but many forms of natural healing cannot be confined to traditional learning environments or classroom or textbook training. 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. Government mandates may miss some of the more intuitive or spiritual dimensions of healing skills which may not be easily defined or tested.

* Governments should allow practitioners to 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.

b. Innovation: Regulation that restricts health care practice to one group and to one standard of care can decrease incentive for innovation. The healthcare field needs healthy competition in the market place and needs the freedom to expand and develop as understanding of healing grows.

* No restrictions should be put in place regarding dissemination of new ideas and information if there is no imminent risk of harm and there is an informed consumer environment.

c. Preservation of Knowledge: Health care regulation must always safeguard against the elimination of age old wisdom and knowledge of healing.

* Preservation of wisdom is accomplished only in a free and uncensored society.

d. Cooperation among Practitioners: Health care regulation that promotes turf battles instead of an interdisciplinary environment decreases the potential for cooperation and exchange of information among practitioners. Practitioners practice in fear of being charged with the practice of medicine without a license or in fear of losing their existing license for practicing outside of a defined scope.

* The least restrictive means of communication should be used to promote acknowledgment and acceptance among practitioners and promote professional coordination, cooperation and free flow of information.

e. Consumer Decision-making: Occupational regulations that limit consumer options take away important rights and motivations of consumers to decide their own healing path.

* Consumer decision making should be encouraged and regulation should support the fact that consumers that participate in their own health care decisions thrive more and have better health outcomes.

Re: Federal Regulations of Communications, Products, and Devices:

14. Federal regulation of communication, drugs and devices is not the least restrictive means of health care regulation and can negatively impact consumer options when used as the sole means of regulation. For example, the federal definition of a drug is the most restrictive type of regulation possible for health care products. Federal law defines drugs broadly to include any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease. Substances that are defined as drugs cannot be used without FDA approval and the approval process involves lengthy expensive studies economically prohibitive for the general public. This law puts an unreasonable burden of proof on the public and outlaws the use of all healing agents that have not been proven safe by the government, even when there is no documented imminent risk of harm and even when the consumer is properly informed. This drastically reduces consumer options and choice of treatments.

15. The Dietary Supplement Health and Education Act is a strong positive reform of the Federal Food, Drug, and Cosmetic Act that protects the right of access of consumers to safe dietary supplements used to promote wellness.

16. The DSHEA amended the definition of food to include dietary supplements; however, the definition of drug remains and has yet to be reformed. This reform is needed to secure the maximum number of options for all consumers.

In Summary:

I. 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.

II. Existing regulatory health care statutes should be reviewed and revised to acknowledge and promote the use of the broad domain of healing arts and trades in a nonexclusive manner by all consumers and by all professions both licensed and unlicensed, thus creating the widest range of choices for consumers.

III. A regulatory framework should be utilized that embodies the least restrictive means of regulation, and that provides an informed consumer environment and a system for consumer recourse in the event of a complaint. For state regulation, The Minnesota Complementary and Alternative Health Care Freedom of Access Act of 2000 can be referred to for conceptual planning. For federal legislation, bills amending the definition of the word drug can be reviewed for conceptual planning.

IV. Government should look to the future and create laws that allow for the greatest amount of innovations and that ensure freedom of consumer access to all health care options.

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Minnesota Natural Health Legal Reform Project
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MINNESOTA'S HEALTH CARE FREEDOM BILL SIGNED INTO LAW

May 26, 2000

In a world looking for freedom to access to alternative health care, Minnesota has found an answer. On May 11th, Governor Jesse Ventura signed the Complementary and Alternative Health Care Freedom of Access bill into law. With that signing, Minnesota protected freedom of access to health care as a basic freedom that people enjoy, along with freedom of speech and freedom of the press. Few choices are so fundamental and important as is the choice of how we shall recover from illness or improve health.

Freedom of Access The successful reform caps a grassroots campaign, waged over several years, to better assure consumer access to the kind of health care that is wanted. The bill's enactment marks a step forward for protecting consumer access not only in Minnesota, but also throughout the land. The bill has also been hailed as a bellweather signaling a long overdue recognition of freedom to practice for alternative health care practitioners. A consumer's freedom of access is dependent on the practitioner's freedom to practice, of course, much as the public's freedom of access to information rests on the writer's freedom to write freely and without suppression by state laws or actions. For many, the unfair suppression of health care practices is just as troubling and unacceptable as would be the state's censorship of books or of free speech.

How the Movement Started The health freedom movement in Minnesota was galvanized in the mid-90s by high profile legal actions taken against several of the state's most prominent alternative health care practitioners, both licensed and unlicensed. One case involved St. Paul naturopathic doctor Helen Healy, who was charged with "practice of medicine" without a license. Despite the absence of consumer complaints and even despite the absence of any allegations of patient harm, the state's Medical Board sought to shut down Healy's practice immediately and permanently. The public outcry helped save Healy from being shut down; she settled out of court before her trial. But it also helped spur a new thirst for greater protection of consumer freedom of access and a desire to affirm the practitioner's right to practice with fairer treatment under the law. A citizen 'legal committee" that researched the legal obstacles to health freedom eventually became the nonprofit Minnesota Natural Health Legal Reform Project, which spearheaded the legal reform effort.

The Overly Broad Definition The crux of the problem for all unlicensed practitioners, including Helen Healy, is the overly broad definition of the "practice of medicine." The sweeping definition includes anyone who undertakes to diagnose, correct, treat or even prevent any disease, illness, pain or infirmity by any manner or means; such people are practicing medicine, according to existing law, and must be licensed medical doctors. Nurses, dentists, chiropractors and other licensed health professionals escape charges of practicing medicine without a license because they have an exemption to the overly broad statute. But there is no such protection for the unlicensed alternative health care practitioner; they can be charged with practice of medicine whenever a complaint gets the medical board's attention. The fallout of this legal vulnerability is far-ranging: it includes a fear of becoming too prominent, a fear of being too commercially successful, a fear of being the innovator and a fear of being seen as outspoken in criticizing the more commonly used methods of treatment. As a result of the fear and intimidation, consumers can tend to be deprived of the benefits of the most honest discussions that they could have with their practitioners, and of the most innovative treatment methods. The practitioners themselves may be forced into early retirement or they and their treatment option could be difficult to find.

Licensure and Turf Battles If the state of Minnesota deems it desirable to regulate an occupation, it is state policy to only regulate the occupation with the least restrictive manner and only when an occupation would pose an imminent risk of harm to the public. In view of that, legislative health committees have declined to allow licensure for currently unlicensed modalities such as naturopathy to go forward. A registration bill for massage therapists has also been tabled. Licensure and registration approaches have other drawbacks; they seem to set up battle lines among practitioners, between those that would be allowed to practice under the proposed licensure and those that would be excluded. Minnesota's new approach to affirming health freedom avoids stirring up those kind of turf battles.

Minnesota's Freedom Solution. To assure consumer access to as many practitioners as possible, the state of Minnesota has set up a new office to provide government oversight to unlicensed practitioners. In turn, the practitioners practicing under the new statute will be exempt from criminal charges of practice of medicine without a license. The office will oversee those who are practicing "the broad domain of complementary and alternative healing methods and treatments." Naturopathy, homeopathy, herbalism, and massage, are just a few of the therapies listed in the statute as examples of practices that the new chapter of law deals with. A set of 24 rules of ethical conduct is given for the new office to oversee. The office will receive consumer complaints, investigate them, and enforce the ethical rules. The ethical rules include prohibitions against fraud, false or misleading advertising, sexual contact with a client, and inability to practice "with reasonable safety ... to the client." The rules of conduct are clearly not intended to allow suppression of therapies on the grounds that they are new or different from conventional practice. "The fact that a ...practice may be a less customary approach to health care shall not constitute the basis of a disciplinary action per se," the new law states.

The new law takes effect July 1, 2001.

How They Did It A statewide grassroots lobbying effort by the reform project helped move the health freedom bill through the tougher committee battles. A core of about eight leaders met one night a week for three years to drive the effort forward. Serving as the reform project's legal consultant was Diane Miller who, supported by a volunteer legal team, formulated the freedom approach behind the bill. Miller along with citizen-turned-lobbyist Jerri Johnson, a local homeopath, led the lobbying work at the capitol and helped to navigate the bill through 15 committees.

Consumers in all parts of the state – outstate as well as metro – played a role in reaching their elected officials. They gathered with their legislators in their districts to share their stories of the personal importance of alternative care options and to demand active reform. After a while, it was obvious that, for the people of Minnesota, this reform bill had very broad support.

The chief author in the house was state Representative Lynda Boudreau, a republican. Her leadership in moving the bill through key house policy committees was crucial. She was able to work with supportive colleagues to survive intense amendment discussions and formulate a bill that would meet new-found broad support.

Then it was largely the senate's turn, with the committee deadline clock ticking. State Senator Twyla Ring, a democrat and a rookie in the senate, was the senate author who piloted the senate version through three major dramatic hearings in one week. Senator Ring agreed to take up the senate authorship after the death of a previous senate author, Senator Janet Johnson, last August. Elected in a special election to fill the vacancy left by Johnson's death, Sen. Ring, had been a personal friend of Johnson's. Sen. Ring became strongly committed to helping finish the senate journey for health freedom that her friend Janet had begun. She did, with the help of many of her senate colleagues.

After going through a conference committee, final passage in both houses was by strong margins. On May 1st, the House approved the bill by 110 to 23, following a final, lively debate. The final senate approval for the bill on May 4th was by a 58 to 1. The freedom train had arrived.

Governor Ventura's policy advisors supported the health freedom bill and the governor's office was deluged with calls from citizens urging that he sign the bill. Without fanfare, Ventura signed with bill May 11th in the privacy of his office.

Contacts:

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Diane Miller, legal consultant & lobbyist	c/o 612 721-3305	
Nancy Hone , local homeopath	651 647-9908	

48. Representative Lynda Boudreau
MN House of Representatives

49. Shirley A. Brekken MS
Minnesota Board of Nursing

50. Stephen T. Bolles DC
NW Health Sciences University

51. Helen Catherine Healy N.D. (Naturopathic Doctor)
Minnesota Association of Naturopathic Physicians

NOTES:
Current legislation in Minnesota does not provide for licensing of 4-year educated Naturopathic physicians. There are no educational standards expected of naturopaths, which means to me that the people of the state will be missing out on the excellence of this "formal" form of medicine.

52. Jerri Irene Johnson, BS in Nursing
MN Natural Health Coalition

TESTIMONY:
One hundred years ago, natural forms of health care were a major and integral part of our society. There were over 100 homeopathic hospitals, and 22 homeopathic schools, as well as botanical and eclectic schools. There was conflict and competition between these practitioners and the allopathic or "regular" practitioners.

Near the turn of the century, the AMA's Council on Medical Education did a survey of medical schools and decided which should be purged and which should be supported. They approached the Carnegie Foundation, and asked them to do another study of the state of medical education in America. Abraham Flexner was commissioned to study medical schools and make recommendations on educational standards.

The conclusion of the study? Only those schools which emphasized the chemical and biological sciences would be accredited. Only those which founded their education on laboratory research would receive the massive funding soon to be made available through the Carnegie and Rockefeller Foundations.

Although this was perhaps a boon to research in the medical sciences, the tragic result of the Flexner Report was that the homeopathic, botanical, and eclectic approaches to health care almost completely died out in America. Rules and laws evolved, which established that only graduates of the approved schools could be licensed to practice medicine. Within 20 years, all of the homeopathic schools had closed The practice of medicine without a license became a criminal offense, punishable in many states by imprisonment. And what was the definition of "the practice of medicine"? Very broad definitions evolved, so that most states now have a definition similar to the Minnesota definition, which says 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. In this manner, most herbalists, homeopaths, naturopaths and others were prohibited from offering their services, and tragically, most American citizens lost access to, and eventually, even awareness of the existence of these healing arts.

Those doctors who did graduate from the approved schools were similarly constrained from

practicing homeopathic or botanical medicine. They could not even consult with a homeopath, for fear of losing their license. Similar restrictions exist to this day, in the form of requirements to adhere to the "acceptable and prevailing standards of care."

The upshot of the movement to mandate types of health education was that the natural healing arts became illegal to practice. Non-physicians could not practice them because it was the "unlicensed practice of medicine", and physicians could not practice anything outside of the "prevailing standard of care."

While in the rest of the world, the natural healing arts have flourished, developed, and become a substantial part of health care, in America, they vanished for decades.

Today, we stand at a crossroads for health care in America. Natural health care has resurged in popularity as it has been rediscovered by the people, but much of it still remains illegal to practice in most states.

You good folk, who truly love holistic health care, and care about American's access to it, are charged with making recommendations. In your passion for desiring the growth of natural health care, beware of instituting burdensome education mandates, or trying to force the education for the natural healing arts into an institutional system. We might inadvertently end up suppressing natural health care all over again. Only this time, we will have done it to ourselves.

(Background materials attached next page)

3:30 – 3:45 pm BREAK

Recommendations to the White House Commission on Complementary and Alternative Medicine

Minnesota Natural Health Legal Reform Project

The Minnesota Natural Health Legal Reform Project is a grass-roots citizen-based group that works to ensure citizens' legal access to the health care provider and modality of their choice. In May of 2000, we succeeded in passing the *Complementary and Alternative Health Care Freedom of Access Bill*, which devised a creative new way to allow a broad range of health care practitioners to legally practice, thus ensuring maximum citizen choice in health care options.

The following are our findings and recommendations to the White House Commission on Complementary and Alternative Health Care Policy:

Regulation of Practitioners

Findings

- 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.

- Every person has the right to utilize the health care practitioner, treatment , or information source that he or she desires. Citizens have this right regardless of the practitioner's education, training and experience, and regardless of whether the treatment they seek is socially acceptable, well known, "scientifically proven" or generally recognized.

- Many natural health therapies have been used since the beginning of time, and tend to be safe, non toxic and non-invasive. These natural healing arts should be as accessible as possible to all citizens.

- Just as citizens' rights to have freedom of information requires freedom of the press, and just as our rights to practice the religion we choose requires freedom of religious organizations to operate, so the right of citizens to access the healing modality of their choice requires the right of practitioners to be able to practice their trades.

- The biggest obstacle to the use of natural therapies has been the passage in the early 20th Century of medical statutes in almost every state which prohibit "the unlicensed practice of medicine," thus making it illegal for most people to practice any of the healing arts unless they were a licensed physician.

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

- The role of government regulation is to protect citizens' rights to individual choice and autonomy and to protect them from harm. The public interest is served when citizens have the freedom to make their own choices and the widest possible variety and diversity of options is available to them.

- Licensure works by mandating a required type and extent of education, and restricts individuals who have not met those requirements from practicing. Licensure is not appropriate for many of the healing arts, as it sets up a false assumption: that specific academic criteria are required for an individual to assist someone with the age-old wisdoms of health care.

- Because licensure is so restrictive, it should only be used when necessary to protect the public.

- Licensure requests are often brought for other reasons, such as a desire for third-party reimbursement. Although often advocated for as required to protect the public, typically requests for licensure have been brought by groups of practitioners, not the public asking for protection

- There is a need for legislation to allow unlicensed providers of complementary and alternative health care to practice without fear of criminal prosecution for "practicing medicine without a license."

- Legislative reform can provide a regulatory framework for a broad range of natural health practitioners without requiring licensure.

- Licensed health practitioners also face restrictions, in the form of inability to practice outside of the prevailing standard of care. Practitioners who use therapies that are different than the prevailing standards face the threat of loss of their license, even if the care they use causes no harm.

- The necessity of adhering to the "prevailing standard of care" often inhibits licensed practitioners from utilizing complementary and alternative therapies for their clients.

- Licensed practitioners who are sanctioned for practicing complementary and alternative therapies often feel unfairly treated due to the broad powers of the licensing boards.

- Legal reform is necessary to open up ways for these providers to practice outside of their standard of care, while providing citizens maximum information regarding options in their care.

Recommendations

- Freedom of access legislation, which allows unlicensed providers to continue providing the healing arts to citizens, should be introduced in every state. This legislation should:

  provide a regulatory framework for the broad range of healing practitioners without requiring licensure.

  provide an exemption from the medical statute for those practitioners under the regulatory framework, where the medical statute makes it illegal to practice

- The Minnesota Natural Health Legal Reform Project Recommends that Minnesota Statute 146A, the Complementary and Alternative Health Care Freedom of Access Act, be referred to

- There is a need for government funding for research in complementary and alternative therapies, particularly because the typical funding of research relies on profits from the development of procedures or substances which can be patented. However, the natural healing arts and healing substances, being not patentable, do not receive this financial support.

- Access to complementary and alternative therapies should not be dependant on documentation and research patterned after types of research done in conventional medicine. Citizens often find success in using health care methods that have not been researched, and they make evaluations based on their own experiences. They should continue to have access to the modalities they prefer.

- High standards of accountability regarding conflict of interest are needed by government regulatory agencies such as the FDA. Representatives of corporations which manufacture and market vaccines or pharmaceutical drugs should not be on FDA panels which evaluate and approve these products.

- There should be no "revolving door" arrangements allowing an employee or board member of a regulated industry to secure a position with the agency which regulates its products.

CONSUMER ACCESS/REIMBURSEMENT

Findings

- The first requirement for citizen access to the healing arts is that a way be found for the services to be legally practiced. As consumers, we feel our innovative new Minnesota Statute 146a effectively addresses that question for unlicensed practitioners.

- The use of natural therapies through health promotion and disease intervention is often extremely cost-effective and, if implemented, could help to lower health-care costs.

Recommendations

- Citizens with third-party coverage should be able to choose the type of health care and the practitioners that they prefer. The broad range of the healing arts and of practitioners should be an option for all citizens.

- Medical savings accounts and other ways of defining contributions available, rather than defining benefits covered, can help to give citizens more control on how to utilize their health care dollars, while avoiding restrictions on what can be covered.

- We believe there is a need for creative and new ways of looking at reimbursement. The past reliance on government regulation and educational standards does not fit well with the nature of complementary and alternative therapies. Holistic healing is a different paradigm from conventional treatments, and access to third-party coverage also requires a new paradigm.

- Health care plans need to be developed that put the primary concern on meeting the health care needs of the citizens, not the economic interests of the HMO or other providers.

DELIVERY OF RELIABLE AND USEFUL INFORMATION TO THE PUBLIC

- The dissemination of information to the public has been stymied by the regulatory climate which made the "unlicensed practice of medicine" a criminal offense, and which made it

impossible for licensed health care practitoners to practice outside of the "prevailing standard of care." This legal situation has created a climate of fear, in which practitioners are reluctant to write or speak publicly about their therapies for fear of prosecution. This is a freedom of speech issue, as well as a freedom of practice issue.

- The first step in increasing the flow of information on healing therapies is to make a way for the therapies to be legally practiced. In Minnesota, because of the imminent implementation of the new Statute 146a, practitioners will be able to publicly give out truthful information without fear of arbitrary prosecution.

- There is a need for more factual and unbiased media coverage of complementary and alternative health care methods.

- There is a need for education of conventional medical practitioners regarding complementary and alternative health care practices. This would allow more free flow of information in both directions, to the benefit of consumers. Conventional practitioners could then provide their clients with information about other healing options, and referrals to alternative providers.

Even the Founding Fathers recognized the importance of citizen health freedom. Benjamin Rush, M.D., one of the signers of the Declaration of Independence, wrote:

"The Constitution of this Republic should make special provision for Medical Freedom as well as Religious Freedom... To restrict the art of healing to one class of men and deny equal privileges to others will constitute a bastille [prison] of medical science. All such laws are un-American and despotic."

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 overwhelmingly 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)

TESTIMONY OF ANN RICHTMAN, J.D. / NORTHLAND NATURAL HEALTH RESOURCES, INC.

FOR WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY. MARCH 16, 2001. MINNEAPOLIS, MINNESOTA.

Thank you for this opportunity to speak. I am Ann Richtman. I am an attorney from northern Minnesota and Wisconsin and I was a legal consultant in the passage of the New Minnesota law 146A. I also coordinated publication of a 100-page book on natural health and related issues for distribution in our northern rural areas. I have read the transcripts of testimony presented to you in the past months and would recommend that everyone read Dr. Gordon's book of 1984 *The Healing Partnership*. I will limit my remarks today to three points.

Practitioner Accountability: I think that it would be fair to say that there is an assumption within the Commission that nationally established requirements of licensure or certification are a must for both practice and reimbursement. In Minnesota we did not let that assumption go unexamined. The demand for occupational licensing comes from practitioner organizations, not from consumer groups. We do want competence, accountability, and informed consumers. Our law incorporates consumer protection provisions -- both with regard to prohibited conduct regulated by the Department of Health, and the Client Bill of Rights which requires disclosure of practitioner information so clients can make informed choices.

Despite opposition from the ranks of the medical establishment, the bill passed 58 to 1 in the Senate and 110 to 23 in the House and became the first state law of its kind in the country. However, I want to point out something often overlooked. Most of the language of 146A is identical to a previously existing Minnesota statute for unlicensed mental health workers; one that also has compliance oversight history with the Department of Health. Decision-makers like taking the path of least resistance.

Before you make recommendations about national standards please give us an opportunity to test the merits of our model in its new context and make report in two years.

Informed Choice. As I read through the testimony, I ask myself what is the key issue here and how is it being addressed. "Therapeutic doctrines have important economic aspects." (Harris Coulter) People are sick and tired, and increasingly they are more sick and tired. In our region revenues from medical services industry are second only to iron ore; in the nation they are the largest sector. Our local hospitals have an advertising budget that is unrivaled only by the pharmaceutical companies. Between them there is constant and pervasive multi-level marketing of acute care services and prescription medications in our community –more and more packaged as "news" stories or public service announcements. In America we have an insidious inculturation process from industry and governmental policies that normalizes an expectation of pathological outcome and compartmentalizes self-care as a programmatic option. How will the medicalization

of our society be addressed in your report? Will you make available to us not only the testimony, but also the accompanying written documentation and research provided to you so that we can better inform the public of the wealth of information you are reviewing? And so that we can make an informed response to your recommendations ?

Informed Consent. You are aware that the doctrine of informed consent springs from tort law, although there are those who also see its importance in contractual application. The Supreme Court has told us we have a constitutional right to refuse treatment. But it has also told us that government may substitute it's judgment for ours when it come to having access to the treatment we think most suitable to our individual health needs. Our interests are further compromised by a statutory or judicial requirement that medical doctors advise their patients of "alternative treatments" that are not in any way inclusive of even those alternatives known to you, to us, and to many others outside the narrow confines of conventional medicine. Is patient consent truly informed without disclosure of documented beneficial alternatives?

Again, you are gathering information as part of your process that might broaden judicial, legislative and citizen understanding of "alternative treatments". One example of this, is the testimony presented by Blue Cross/Blue Shield on the cost effectiveness of the Dean Ornish program for cardiovascular disease as an alternative to surgical procedures. Or another is dietary supplements as an alternative to costly and toxic prescription drugs as described by Dr. Alan Gaby. Medical schools and doctors would have to expand their existing knowledge base for the benefit of the patient. We would do more than pay lip service to informed consent and informed choice.

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.

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 do 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
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.

<u>Regulations</u>

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
Charles Reinert, PhD
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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).

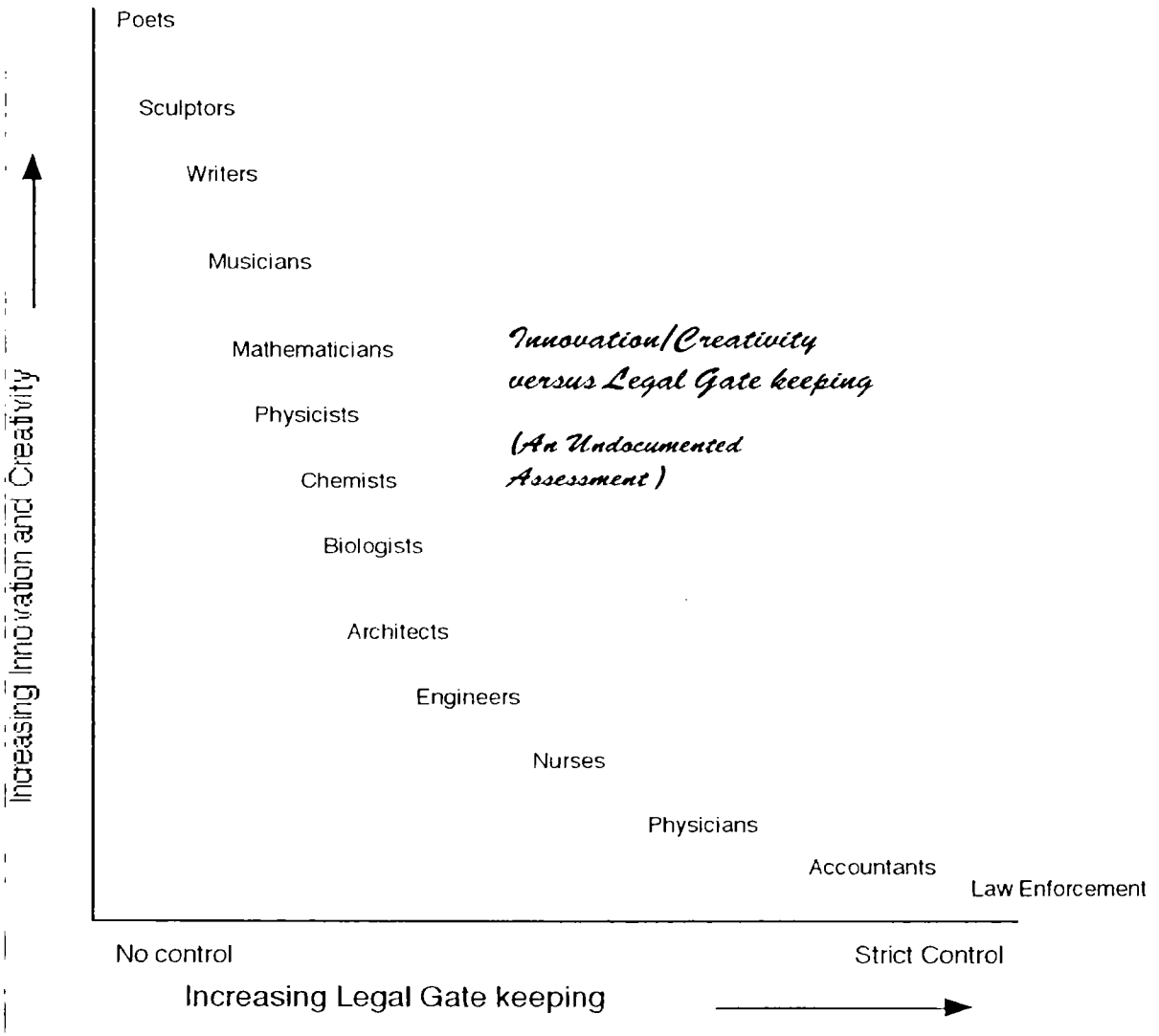
In summary, good, unbiased research is needed to support the many diverse tools in heath care **fair representation must be provided on all funding committees**, so that the results of the research are not only useful but also valid, especially for those protocols which are not currently mainstream.

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

References Cited

Bridgestone/Firestone Centennial Wilderness project See www.centennialforest.com

Dutch Elm Disease See http://pine.usask.ca/cofa/departments/hort/hortinfo/trees/elm-1.html

Twain, Mark; quoted by Aaron John Loeb in *The Wit and Wisdom of Mark Twain* (Barnes & Noble, 1996)

Weil, Andrew MD, *Health and Healing* chapter 2 (Houghton Mifflin, 1983)

Becker, Robert O. MD, *The Body Electric*, "Political Science" (Morrill, 1985)

Kuhn, Thomas S., The Structure of Scientific Revolutions (University of Chicago Press, 1962)

Peterson, Melody, "Pushing Pills With Piles of Money", New York Times On The Web, October 5, 2000

We have many legislators to thank for helping us pass this first-of-a-kind, precedent-setting legislation. They did so with wisdom and courage. We encourage you to thank them with a note, call, or e-mail.

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Ensuring Freedom of Access to Natural Health Care

May 2000

Complementary and Alternative Health Freedom of Access Act Signed into Law

Statute 146A Signed by Governor Jesse Ventura on May 11, 2000

Legislature Votes: House 110-23; Senate 58-1

How Does the New Act Work?

Nuts and bolts: Firstly everyone should know that this statute goes into effect on July 1st, 2001, so we have some time to adjust. The number of the new statute is Minnesota Statute 146A. Currently you can find the text of our bill on our web site (www.minnesotanaturalhealth.org) imbedded in Conference Committee Report 3839 beginning at Section 9. However after the conference committee report is statutorized and made into Minnesota Statute 146A you will also be able to find that on our web site. You can also call House Information at the capitol at 651-296-2146 and they will send you a copy of House of Representatives Conference Committee Report 3839.

There are three important components to this statute:

The first is jurisdiction. The question is: Which practitioners will be available to consumers and will be able to practice as unlicensed complementary and alternative health care practitioners under the Department of Health's jurisdiction and be exempt from charges of practice of medicine without a license? The answer is twofold. First a practitioner must, in fact, be practicing unlicensed complementary and alternative health care as defined in the new statute. The practitioner cannot be practicing modalities that are outside the limits set forth within the law. A practitioner, for example, cannot engage in practices such as surgery, administering or dispensing controlled substances, practices that puncture the skin, etc. Secondly, it will be relevant whether a practitioner is currently an unlicensed or a licensed health care practitioner and if they are licensed whether they hold themselves out as a licensed professional. A close read of the new statute will help you discern whether this statute relates to your situation.

The second important component is grounds for disciplinary actions of practitioners. The question is: If a practitioner is under the jurisdiction of the Department of Health under this new statute, are they abiding by the proper conduct code or are they practicing prohibited conduct. The grounds for disciplinary action are spelled out clearly in the statute and are important for consumers and practitioners alike to be aware of.

Thirdly, and most importantly, is the Client Bill of Rights. The question is: If you are a consumer, did your practitioner provide you with the Client Bill of Rights before treatment commenced and did they have you sign an acknowledgment of receipt of the Bill of Rights before treatment commenced. The Client Bill of Rights mandates that every practitioner provides the client with 17 areas of information before treatment begins, including for example: the name, complementary and alternative health care title, business address, and telephone number of the practitioner; the degrees, training, experience, or other qualifications of the practitioner regarding the complementary and alternative health care being provided; a disclosure in bold letters that reads "THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY

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COME CELEBRATE OUR VICTORY!!

When: Sun. June 11, 2000; 2 pm-6 pm

Where: St. Stephen's School Gymnasium, 2123 Clinton Ave. S. in South Minneapolis. Use entrance on Clinton closest to 22nd St.

Directions: 35W to I-94 West to Lyndale Ave. Exit turning left (south) to first stop light at Franklin Ave. Turn left (east) on Franklin going about 1/2 mile to Clinton Ave. Turn right on Clinton Ave. and go less than one block to St. Stephen's School. Park in lot or on the street.

Who: All of you Health Freedom Fighters

MEET THE AUTHORS, MOVERS AND SHAKERS WHO MADE THIS A REALITY.

The church requests no alcoholic beverages.

QUESTIONS? Call 612-721-3305

How Does the New Act Work continued from previous page

AND ALTERNATIVE HEALTH CARE PRACTITIONER. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY." Every consumer should be aware of this practitioner mandate to distribute a Client Bill of Rights so that they can reap the benefits from the helpful information that practitioners will be providing. You can find the complete Client Bill of Rights in the new Minnesota Statute at Sections 146A.11.

It is not the intent of this article to cover every aspect of the workings of the new statute. Consumers and practitioners are encouraged to read the actual statute which is now Minnesota Statute 146A. Classes and seminars will be available for those interested in a more comprehensive discussion. Please call 612-721-3305 for more information.

Final Version Meets Freedom Goals!

What does the final version of the Complementary and Alternative Health Care Freedom of Access Act look like? Our end product legislation meets our goals and is still our "baby!" We found out that the process of passing successful legislation is akin to a parent's adventure of raising a newborn. You wouldn't think a parent's pride could get any bigger than the day their little bundle was born. But then hearts swell and buttons burst at graduation when their 18-year-old walks down the aisle grinning from ear to ear. Let's not talk about when they backed in to the neighbors' Porsche while practicing driving! Yes, we had a few of those challenges with our bill too. But growing pains or not, our bill is still as beautiful as the day it was introduced into the Minnesota legislature, February 1999. It has been shaped by the climate, expectations and the culture of the state.

For example: The first draft of legislation was one page and requested an exemption from the "practice of medicine" criminal charge for healers that were not harmful or fraudulent. This was done in 1995 during the State v. Saunders trials. Seems simple enough. But before it could be introduced, the next drafts were started and came in response to the Board of Medical Practice v. Helen Healy hearings in 1996. These drafts expanded the language requesting that a government entity not be able to take criminal or civil injunctive action against any licensed or unlicensed practitioner without showing harm or fraud. This was consumer driven and the word started to get out about just how outdated the current laws were. The third set of drafts in 1997-98 were drafted specifically so that consumers would not lose access to natural therapies due to restrictive or unnecessary licensure laws. These drafts created a new model of legislation for all the complementary and alternative health care community and was 6-7 pages long. It included "right to practice" language for practitioners and proper "disclosures and informed consent" for consumers. The fourth drafts in 1998 were direct responses to preliminary discussions with legislators who recommended that there be a special office that could direct consumer complaints to proper legal avenues. **The most common concern of legislators was how to protect the public when no licensure, registration or certification was required.** A designated government client contact phone would help refer consumers to the already existing legal avenues available. The Department of Health agreed to be such a referral office. And finally the fifth set of drafts came in early 1999 and included all of our preferred language which we were courageously ready to defend at all costs. The bill was entitled the Complementary and Alternative health Care Freedom of Access Act and was introduced February 8, 1999. This stage was like eighth grade graduation!

Our bill was considered by some to be very raw. We, on the other hand, perceived it as a fine pearl, "all growd up" – typical freshmen! Some legislators saw the bill as very progressive, allowing the maximum number of consumer options and providing a referral service to teach consumers about their existing legal recourse when they had a concern. Other legislators opposed the bill, wanting a licensure model to mandate particular types of education and give exclusive title to various groups. Our task became one of educating legislators about the wide variety of healing trades and arts, about the lack of number of complaints against natural health practitioner and the potential arbitrariness of legal actions taken against them, and about the 1998 Department of Health Study on Complementary Medicine which did not recommend licensure but rather recommended a new

Celebrating after the Senate victory. L-R: Irene Jensen, Jeanne Hollingsworth, Martin Bulgerin, Eleanor Schultz, John Schotzbarger, Jan Forsberg, Leo Cashman, Jerri Jo on, Greg Schmidt, Twyla Ring, Nancy Hone, Diane Miller, Marillyn Beyer.

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Final Version continued from previous page

approach addressing the ethical relationship the consumer has with a practitioner.

AMENDMENTS became the name of the game! It was a full-time job keeping up with them. Our first shocking experience was when that portion of our bill that allowed licensed practitioners to practice alternatives was taken out in one fell swoop after a three minute conversation with no testimony. Wow! What a lesson in politics! We decided to continue and work with the unlicensed practitioner portion of the bill. As the bill went forward the most significant opposing amendment came from the House of Representatives presented in the Civil Law Committee by Representative Carruthers. **This amendment required us to abandon our original language and adopt language similar to an already existing Minnesota Statute for unlicensed mental health care practitioners.** It required us to shift the jurisdiction of the natural health community from the Board of Medical Practice to the Department of Health. It also required the government to set up a new office for enforcement of practitioner ethical violations and mandated distribution of Client Bill of Rights, which in turn required us to ask the legislature for money. But it did not jeopardize our freedom goals to assure consumer access to as many healing modalities as possible. We carefully considered our options and finally decided to introduce a reformed version of the amendment. This enabled our bill to pass out of the Civil Law Committee on February 26, 2000, after being heard in a precedent number of hearings over a course of almost a year by a strong advocate and remarkable Committee Chairman, Representative Steve Smith.

The ramifications of this decision were politically very huge. Not only were our former supporters on board but many of those who had been opponents now were excited about the bill. Consumer calls, letters and e-mails were flooding the capitol, and we had a bill that was gaining momentum. In the Senate the bill moved with less resistance after the Department of Health model language was adopted. The most significant amendment in the Senate came when negotiations took place with a number of licensure Boards. The end result was that the new office in the Department of Health would not have jurisdiction over a person licensed under the Board of Medical Practice, Board of Chiropractic, Board of Dentistry, and Board of Podiatric Medicine. **Other licensed professionals could practice as "unlicensed complementary and alternative health care practitioners" under the Department of Health as long as they were not holding themselves out as licensed professionals while practicing alternatives. All licensed individuals who would hold themselves out as licensed practitioners would continue to be under their licensing Boards when practicing complementary and alternative practices. It was at this point in the process that the Board of Medical Practice voted not to oppose our legislation.** These were extremely important amendments and contributed to the mutual respect of all participating interest groups.

The last big hurdle for amendments was the financing of the Health Department office for the taking of and following up on ethical complaints. All along the way there had been many heroes helping us. This included getting the funding for this office. The hard-working authors of this bill, Representative Lynda Boudreau and Senator Twyla Ring, were fearless under the attacks of our opponents! Towards the final days, Senator Sheila Kiscaden took the language of our bill and amended it onto her health occupations bill. This was done so that our bill would not get stuck in the huge omnibus bill where it could have gotten stalemated. This allowed it to continue to move ahead through the process. Senator Kiscaden has our deepest gratitude. The bill sailed through the last week while we held our breaths. MNHLRP, the Senate, and the House had worked together to find common ground, and we had found it. The bill even got the signature of the Governor! Hurray!

And now, like the teenager graduating and meeting the world head on, we expect a time of transition for our "freedom statute." We plan to participate in this transition, and continue vigorously advocating for natural health care freedom.

WHY DO WE STILL NEED MONEY?

- There is still much to do to insure that consumers have access to ALL practitioners of complementary and alternative therapies both in Minnesota and on a national basis. Consumers want access to practitioners both inside and outside of the medical system.
- We must educate consumers and practitioners on how this first of a kind legislation works.
- We must watch over this new bill probably forever to protect it from unwanted changes.

Please be generous with your donation – help is needed now!
Together we can change the face of the nation!

____Whatever you can give ____$35 ____$55 ____$100 ____$500 ____$1000+

Send contributions to: MN NATURAL HEALTH LEGAL REFORM PROJECT, 3236 17th Ave. S., #1, Mpls., MN 55407

Because the Legal Reform Project is for lobbying purposes, your contribution is not tax deductible. If you prefer a tax-deductible contribution, please contact us as we do have a nonprofit coalition for educational purposes that welcomes funding also.