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WHCCAM Town Hall Meeting Testimony, Minneapolis, Minnesota, March 16, 2001

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RESTRICTION CODES

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PEOPLE AGAINST CANCER

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Frank D Wiewel – Statement to the Whitehouse Commission on Alternative Medicine

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Minneapolis, Minnesota (March 16, 2001)

Cancer. You read about it - you hear about it - you see it on TV. But there is one thing you are never told - **you are never told the truth about cancer.**

You are never told the truth about cancer incidence - In 1960 1 in 4 Americans would face cancer - today it is 1 in 2. **This year, over 1,500,000 Americans will get cancer.**

Despite these horrifying facts, the Cancer Establishment claims that progress is being made in the fight against cancer. **You are never told the truth about cancer incidence.**

You are never told the truth about cancer death. Death from cancer is on the rise, experts say it will soon overtake heart disease as the #1 killer. **This year over 750,000 Americans citizens will die - notwithstanding the best conventional therapy! You are never told the truth about cancer death.**

You are never told the truth about cancer diagnosis. The public is told that the earlier the diagnosis the better the chance of a cure. It's a lie! Through the use of scare tactics, many forms of cancer are now being diagnosed at a much earlier stage producing a "statistical cure" but no real survival advantage. Radiation from mammograms and x-rays is a major cause of cancer. In a Canadian Breast Cancer Study, routine yearly mammograms for those ages 40 to 50 produced a 52% increase in cancer. **You are never told the truth about cancer diagnosis.**

You are never told the truth about what causes cancer. Recently, the American FDA found traces of 60-80 toxic pesticides in the average American food basket. Despite the



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fact that there has never been a single study demonstrating the safety of this amazing combination of toxic substances - **Incredibly, the US government did nothing.**

You are also never told the truth about cancer prevention. We can lower our risk of cancer by eliminating carcinogens from the food, air, water, and environment. There is also good scientific evidence that we can significantly lower the risk of cancer with exercise, dietary changes, nutritional supplements and stress reduction.

You are never told the truth about conventional cancer therapy. For decades, the cancer establishment has foolishly relied upon the crude and primitive treatments of surgery, radiation and chemotherapy as their only weapons. **These therapies are generally dangerous, toxic, ineffective and highly profitable. There is an on-going deliberate and sophisticated hoax being perpetrated on people with cancer.**

You are also never told the truth about Innovative cancer therapies. There are promising new methods of treating cancer that are safe, effective and cost effective. Amazing discoveries about the power of nutrients to prevent and treat cancer are being made every day. Nutritherapy is the use of therapeutic doses of nutrients to resolve disease. Nutritherapy is the future of medicine. Chemotherapy and radiotherapy are the past. However, nutritherapy will never be approved under the current FDA protected medical monopoly scheme.

The White House Council on Alternative Medicine has the opportunity to tell the truth and demand reforms of the current system. The Commission has the opportunity to bring together physicians and researchers and people with cancer to discuss “new directions in the war on cancer,” and research new strategies for cancer prevention and therapy through the use of the mind and body, diet, nutrition, detoxification and through the high tech biologicals.

In America alone we have spent over one trillion dollars for research and treatment. **Cancer incidence is up. Cancer mortality is up. And the cancer industry calls it “progress.” The truth is - as we approach the turn of the century, the greatest enemy we face is not cancer, not heart disease, not AIDS - but the medical monopoly.** It has been said in any war the first casualty is often the truth. And so it is in the “war on cancer.” It is a massive medical monopoly. Monopolies do what monopolies do - they seek to eliminate competition and gain market share. **We must have a top-to-bottom restructuring of the multi-billion dollar Cancer Program in America.**



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What needs to be done?

- 1) **For People With Cancer** - we need to tell the truth, the whole truth, and nothing but the truth!
- 2) We need to conduct good scientific research and tell people there are innovative and alternative therapies that are safe, effective and cost effective.
- 3) We need to tell people – “You can do more for yourself than any doctor.”

Suggestions For Reform of the System

- 1) We need to dismantle the FDA and the National Cancer Institute – they cannot be reformed!
- 2) We need to re-establish all of the National Cancer Advisory Boards as “Citizen Cancer Advisory Boards.” The new boards should be controlled by people with cancer, not cancer physicians and cancer researchers with a vested interest.
- 3) We need to demand that the National Cancer Institute and the Office of Alternative Medicine ONLY fund evaluations of therapies that can NOT be patented and DO NOT have pharmaceutical support. The government should not be helping the malignant pharmaceutical-cartel – they are vicious criminals who have little interest in human health.
- 4) As a start, the National Cancer Programs should earmark a minimum of 50% of their funds to go to the evaluation of real alternative and innovative cancer therapies and increase the funding by 10% per year until they reach 100%.
- 5) We need to establish a fair and permanent mechanism to scientifically evaluate alternative and innovative therapies for safety, efficacy and cost effectiveness.
- 6) And most important - we need to pass the Access to Medical Treatment Act and the Thomas Navarro Health Freedom Act. Both acts are now before the US Congress to allow physicians and people with cancer the right to use alternative and innovative therapy.



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The ultimate goal of medical research is finding innovative methods of preventing and resolving disease. As a people, we must work together to promote innovation in medicine - not suppress it. We must work together to promote and protect the free flow of information on innovative alternatives to our citizens who so desperately need it. This year 1,500,000 American citizens will be diagnosed with cancer and over 750,000 Americans will die despite the best conventional therapy. As a country, we cannot afford to overlook any alternatives for any reason.

People Against Cancer is a non-profit public interest group dedicated to new directions in the war on cancer. Established in 1985, they have worked to promote the scientific evaluation of promising innovative therapies for cancer. Frank Wiewel, the director of People Against Cancer was a member of the National Advisory Board of the Office of Alternative Medicine (OAM) in the National Institutes of Health (NIH) and the chairman of the Committee on Pharmacological and Biological Treatments. He was one of the original drafters of the Access to Medical Treatments Act (AMTA) a bill now before Congress to allow physicians and patients the freedom to choose innovative therapies not yet approved by FDA.



15th WONCA World Conference

'People and their family doctors - partners in care'

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NAME(S) OF AUTHOR(S) (Underline presenting author)	<u>Milton Seifert</u> Eagle Medical P.A. Excelsior, Minnesota USA		
INSTITUTE NAME AND ADDRESS			
PRESENTATION CATEGORIES:	START HERE:	Introduction: Our medical practice began in 1972 with a belief in and a commitment to partnership health care. This has been maintained over time with an organizational strategy known as the 4C2A formula: comprehensive and continuing; coordinated and customized; accessible and accountable. Arising from this is a technology for health status assessment that has the capability of inducing systemic change. Methods: Using the grounded theory approach, patients were enlisted as co-researchers; a language of negotiation was developed and tested; a spiritual health assessment was created; the SF36 was adapted to clinical practice; focus groups were conducted; the technology was tested in other clinics; and the final result was the design of the Health and Disease Questionnaire (HDQ). This questionnaire, influenced by researchers of health, promotes care for health with the same intensity it promotes care for disease. Summary of Results: The HDQ, created with the integral involvement of patients, has meant empowerment for the patient role, assistance for the provider role, and support for their partnership activities. Functionality was measurable in the areas of physical, mental, social, emotional, and spiritual health. Known reliability and validity of the SF36 was confirmed by patients. Neglected patients from other systems were rescued. Populations were measurable. Health care and health care research merged into one entity. Conclusions: This work, combined with the prior work of SF36 development, makes the HDQ a scientifically sound measurement device. Usefulness to partnership health care creates an opportunity for bottom-up systemic change. System economics based on measurable results for individuals and populations would, in time, change the world.	
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DEADLINE FOR ABSTRACTS: September 30, 1997

**Coordination of Patient Care:
Medical Practitioners with Alternative Care Providers**

Author: Milton H. Seifert, Jr.

December 2000

Introduction: A report to the legislature, "*Complementary Medicine*"¹, was published on January 15, 1998 and sent to the Minnesota legislature. This report was published by the Minnesota Department of Health, and Commissioner Anne M. Barry writes the following: "The study of complementary and alternative therapies is a very important and relevant issue in the current health care market. The growth of complementary and alternative medicine in America seems indisputable. In a landmark study published in the New England Journal of Medicine in 1993, Dr. David Eisenberg and his colleagues found that one in three patients in the United States regularly use complementary and alternative therapies."

Commissioner Barry goes on to say: "As the legislature has indicated through mandating this report, it is important to begin to explore the potential implications of the increased use and acceptance of complementary and alternative medicine in Minnesota. The Minnesota Department of Health has an interest in assuring consumers' access to quality forms of health care. Our mission is to protect and promote the health and well being of Minnesotans." The "*Complementary Medicine*" report advanced a number of definitions, studied the efficacy and safety of complementary and alternative therapies, looked at the present state of complementary and alternative research, studied the importance of this movement in the U.S. and around the world, compared availability and utilization of complementary and alternative medicine in the U.S. compared with that of Minnesota, and ended with their thoughts on the purpose and types of regulation that should be considered. Commissioner Barry called this "one step" toward the goal of fully assessing and assuring that the health care delivery system meets the needs of the population.

Minnesota State Statute 146A was signed into law by Governor Jesse Ventura on May 11, 2000. Its title: Unlicensed Complementary and Alternative Health Care Practitioners and Clients². This legislation had passed both houses of the legislature with large majorities. The grass roots support was called unprecedented. This law will have a substantial effect on the practice of medicine in Minnesota, as well as on the writing of this protocol.

State Statute 146A lists twenty-two specific complementary and alternative practices and commented that the domain was not limited to those listed in the legislation. The Office of Unlicensed, Complementary and Alternative Health Care Practice was created in the Minnesota Department of Health and given the responsibility to investigate complaints and to enforce disciplinary actions against unlicensed practitioners who violate prohibited conduct. This office was also expected to serve as a Clearinghouse on complementary and alternative health care practices. It has now been left to the commissioner to adopt rules necessary to implement, administer, or enforce the provisions of this Act.

However, in all health care delivery, regulated or not, licensed or not, the effectiveness and the safety come down to each individual practitioner-patient relationship. While some may still question the importance of this relationship, one group is absolutely clear about its value. They are known as medical malpractice insurers. The loss prevention departments of these carriers have for some time recognized the value of employing techniques to increase patient understanding and satisfaction. They have long been telling practitioners to improve physician-patient relations and have provided a number of educational seminars as well. Thus, the practitioner-patient relationship will necessarily have a prominent place in the ensuing protocol.

Complementary and alternative providers are frequently referred to by the acronym CAM, so for the purposes of the remainder of this paper, CAM will be used to mean complementary and alternative medicine.

Informed Consent:

Michael H. Cohen, JD, MBA, MFA³, writing in the journal *Complementary Health Practice Review*, Fall 2000, says the following: "Informed consent presents one of the major unresolved areas in the integration of complementary and alternative therapies into the health care system". He goes on to say that no court to date has expressly ruled that a physician must disclose the availability of complementary and alternative medicine alongside conventional care and that informed consent rules to date have failed to address the medical profession's growing exploration of complementary and alternative medicine. What is required are credible levels of scientific validation of specific therapies and these are yet to come. At the present time, Mr. Cohen would support a good faith attempt at disclosure, but within the physician-patient relationship.

It is difficult to conceive what kind of disclosure would be appropriate for a system of health care that has not yet emerged, such as the integrating of homeopathy, acupuncture and conventional medical practices. Similarly, we don't know the pharmacological interactions between conventional pharmaceuticals and Chinese or Tibetan herbs. One of the trademarks of CAM is its emphasis on factors outside biochemical, pharmacological, and scientifically accessible explanations. More frequently than not, CAM therapy is paradigmatically foreign to those with conventional medical training.

While it would be difficult for a medical practitioner to describe the "risks" of altering the flow of chi or the use of the low dilution medicines of homeopathy, Mr. Cohen recommends that there be deeper collaboration between physicians and CAM providers in order to create comprehensible disclosure rules. He also believes it is advantageous to bring CAM into the conventional physician-patient relationship. He believes that knowledge of CAM will loosen medical intolerance of therapies outside of orthodoxy, increase medical innovation, reduce misunderstanding, and lower malpractice risk.

Therefore, referral to a CAM provider by a medical practitioner will require at least two negotiation processes that reach consensus. The first negotiated process for informed consent will take place within a partnership of physician and patient and in an atmosphere of conversation and shared exploration. (This format is rapidly becoming a conventional

medical practice standard.)⁴ The second negotiated consensus would occur between the medical and CAM providers, and also within an atmosphere of conversation and shared exploration. It is now clear that these steps are necessary for patient protection and absolutely necessary to achieve coordination of patient care.

Berkeley Rice⁴, senior editor at *Medical Economics*, writes about "The New Rules on Informed Consent" in the June 19, 2000 issue. The author notes that recent court decisions have increased the demands for disclosure and that in a recent review of 85,000 malpractice suits, Physician Insurers Association of America found that one of the most common secondary claims was "failure to inform".

The old standard was what the average doctor thought his patient should know, while the new standard is what a reasonable patient would want to know before undergoing a proposed test or procedure. Now conventional physicians are being advised to solicit patient's opinions in reaching a joint decision on treatment in order that their patients can be truly informed and able to take part in the decisions that are ultimately made. Once again, this is the process of negotiated consensus.

A study published in the *Journal of the American Medical Association*, December 1999, looked at 1,000 patient encounters to see if all the alternatives of conventional medicine were discussed and whether or not patients understood the clinical decisions affecting them. It was concluded that fewer than 10% of the clinical decisions met the standard for informed decision-making. So even though this is strictly conventional medical care, the contemporary requirements for informed consent now require a real dialogue within the context of a real physician-patient relationship.

Since informed consent within both conventional medical care and CAM health care requires better practitioner-patient relationships, it would be worthwhile to look at the types of relationships familiar with health care services as described by Richard Magraw, MD⁵, in his book, *Ferment in Medicine*. These include the following:

Activity/Passivity: This type of relationship is one in which the physician is active and the patient is passive. This has its origins in, and is entirely appropriate for emergency situations such as the treatment of severe injuries, the use of anesthesia, and undergoing appendectomy. Treatment takes place regardless of the patient's contribution. The relationship of the doctor to the patient is similar to that of the parent to the helpless infant.

Guidance/Cooperation: This is the relationship of choice for acute myocardial infarction or an acute infectious process. The patient is aware, is capable of following directions and of exercising some judgement. The physician tells the patient what to do and the patient obeys. It is most like a parent-child relationship.

Mutual Participation: In this relationship doctors help patients help themselves. Patients use expert help by means of partnership with their physicians. It is the relationship of choice for chronic illnesses, such as diabetes mellitus, coronary

heart disease or essential hypertension. The physician has an awareness of the patient in personal terms and, in the doctor's view, the disease is incidental to the person. It is most like an adult-to-adult relationship. It is the relationship type most appropriate to CAM referral, delegation, follow-up, and coordination of patient care.

CAM Provider Credentials:

The author has served on credentialing committees for organizations and systems for both conventional medical and CAM providers. The report to the Minnesota legislature, *Complementary Medicine*¹, notes that CAM practitioners have very diverse educational backgrounds and their training in some of the therapies may be obtained from several different sources and this training is certainly not the same for each practitioner, even within the same CAM specialty. The spectrum of education goes from formal education in an accredited institution to short courses and workshops. Thirty-four medical schools in the United States, including Harvard, Yale and Johns Hopkins, are offering coursework in alternative medicine. For all of the CAM professions in Minnesota, the only two that are licensed are chiropractic and acupuncture.

The field of CAM is very broad and diverse and includes many systems of care. The National Institutes of Health have established the Office of Alternative Medicine to promote and guide high quality research and to bring information on CAM to clinicians, researchers and consumers. The CAM projects that are being funded and the eventual publications are a beginning body of knowledge about CAM medicine.

Under State Statute 146A, CAM providers are required to provide the Client Bill of Rights to each patient before the treatment begins. This Bill of Rights provides the patient with seventeen areas of information, which include: name of provider, CAM health care title, business address, telephone number, training, experience, and degrees that have been achieved. This then would serve as one type of credential for the patient and the referring medical practitioner.

A medical practitioner seeking to refer to a CAM provider can learn about educational achievement, whether or not the provider is licensed, and perhaps find some literature in a peer reviewed journal, but otherwise the credentialing of CAM providers is not comparable to the credentialing of medical practitioners. Before State Statute 146A, CAM providers were frequently associated with other licensed professionals. That association was often relied upon as a type of credential and provided a way to judge safety and effectiveness.

The author was a member of the Infinite Health Network and a member of the Provider Board, which credentialed every new member. This very well conceived network of CAM providers reached 125 members and all went through the credentialing process. One could observe a great deal of diligence and integrity in this process, but associates, associations, and reputation were often as important in the final judgement as were education, training, certification or licensure. Once again, it appears that science, safety

and effectiveness still comes down to relationships and especially to the individual practitioner-patient relationship

Referral, Delegation, Coordination, Follow-up:

Referral, delegation, coordination, and follow-up are all key elements in the process of health care. Other key elements include the partnership of practitioner and patient and the health care system itself. Thus, an illness is seen within the context of the whole person and the practitioner-patient relationship is seen within the context of the whole health care system. W. Edwards Deming⁶ has informed us that a system accounts for 80 percent of the human behaviors while the individuals account for only 20 percent.

A shorthand summary of this concept is the 4C/2A formula. These stand for comprehensive and continuing, coordinated and customized, accessible and accountable. CAM medicine arises out of a need of the patient for more comprehensive and more customized care. When this happens, a medical practitioner will have to rely on a CAM provider. This is difficult, as noted earlier, because CAM paradigms are often foreign to medical practitioners. Also, a CAM therapy may be awaiting scientific validation or it may not be accessible to the scientific training of a medical practitioner.

Therefore, the relationship between a medical practitioner and a CAM provider is decidedly different than the one between a referring physician and another medical specialist. It appears that the structure of the CAM provider-medical practitioner relationship will have an important effect on the outcome. It seems there are two distinct relationship types in this regard. They are:

- 1) Therapeutically Competent
- 2) Therapeutically Inadequate

Therapeutically Competent Relationship:

The therapeutic relationship is likely to be competent when the dynamics between a CAM provider and a medical practitioner are characterized by listening and caring and mutual respect. They agree to try trust and balance it with intentional accountability⁷. They share the power through a high degree of willingness to cooperate and to place the patient needs foremost (this is a high-grade relationship, but it needs to be, considering the great cultural gap between these professionals).

Therapeutically Inadequate Relationship:

The therapeutic relationship that is inadequate is characterized by lost or missing elements of the competent relationship. When too much is lost or unavailable, then delegation, coordination, and follow-up all will be impaired. Consequently, referral is likely to be too risky and integrative medicine is not possible.

When the relationship between a CAM provider and a medical practitioner is deemed therapeutically inadequate, then medical practitioners must inform patients of their

inability to not only assure the science, the safety, or the effectiveness of a CAM therapy, but that they are also lacking in a good and collegial relationship with the CAM provider. In that circumstance, medical practitioners can seek to establish better, more competent relationships with their patients and together seek out other comprehensive and customized health strategies using the process of negotiated consensus.

Given the above, one would conclude that the collaboration of a medical practitioner and a CAM provider in the care of a patient, could take place only within the context of a high-grade relationship. This would be especially true for the crucial elements of referral, delegation, coordination, customization, continuity, and follow-up.

“It’s driving me nuts!” said a fellow practitioner in recent weeks. He went on to say that a patient with some serious diagnoses was seeking help in a frantic, uncontrolled way. All sorts of providers had been contacted (some questionable) through advertisements, the Internet, and by word of mouth. At the same time, the patient would not accept from this practitioner any advice or referral to a consultant with whom he was familiar. It had left the practitioner confused and worried.

In keeping with the approach we are describing here, a patient such as this could be advised of the nature of therapeutically inadequate relationships and at the same time be offered the elements of a therapeutically competent relationship. If the patient could try the element of trust, this plan could look appealing. In any case, the practitioner would have a safe way to navigate through this problem and possibly help the patient as well.

Integrative Medicine:

This term, Integrative Medicine, is now being used frequently, and in conjunction with, discussions about CAM medicine. This concept would incorporate the ideas of informed consent through the process of negotiated consensus as described above. It promotes research and publication in peer reviewed journals. It would support the development of Therapeutically Competent Relationships between all types of practitioners and their patients, and especially between CAM providers and medical practitioners. It is thought that the collaboration of CAM providers and medical practitioners will eventually lead to the provision of all of the elements of the 4C/2A formula.

Integrative Medicine is the goal of most CAM providers and its scholarly activity is the way CAM medicine can fully develop and achieve patient safety, scientific validation, and outcomes effectiveness. The concept of Intentional Law⁸ could do much to promote this development. These ideas will be described next.

Intentional Law and Extensional Law⁸:

Extensional Law is best known to us in our everyday lives and works best when a “rate” can be attached to a violation. Rates of speed, blood alcohol, or pollution index can be determined with relative ease and their punishment is known to be effective in changing behavior. Extensional Law provides society with protection and restraint, but does not promote the pursuit of well being in society as a whole.

Intentional Law focuses on the systemic and seeks to better society and its institutions, such as security, education, and health care by promoting the achievement of a positive and enhancing environment, in addition to a restraining and governed one. Intentional Law would give the 4C/2A formula the force of law without legislation. It would provide a series of rewards instead of punishments. For example, health care practitioners could be reimbursed better when they achieved better health care outcomes. In the final analysis, Intentional Law leads to, and promotes, the much valued concept of "empowerment" for practitioners, patients, and their working relationship.

The report to the Minnesota legislature, *Complementary Medicine*¹, lists a number of guiding principles in the regulation of CAM medicine. For example, the legislative policy objective of state occupational regulation is protection of consumers. However, another guiding principle is that creative alternatives to regulatory approaches should be sought where possible. Also, regulation should not inhibit innovation in the health care market and in the development of alternative approaches to health care, except when necessary to protect the consumer. Similarly, consumers should have the broadest market access possible to complementary, cultural, and alternative health care practitioners as long as safety is assured. Regulation should interfere as little as possible with the availability of CAM providers.

It would appear that the concept of Intentional Law would apply usefully to the development of "creative alternatives" to regulatory approaches. It is known that regulation seeks the minimum acceptable standard, while accountability seeks the highest possible standard. Higher standards are doable when practitioners are involved in the process in an intentional way.⁹

Intentional Logic^{7,8} leads to a form of governance that *requires* rather than *inhibits*. In health care, it would restore personal liberty to practitioners and patients and permit them to adopt the highest possible standards for themselves. It allows the freedom to attain the optimal result. Intentional accountability produces governance that creates individual liberty while fostering methods of accountability, including self-management, self-control, and self-governance.

A rational and efficient health care system that incorporates the principle of intentional accountability, while remaining congruent with societal values would design specifications and measurements of desired outcomes into the everyday health care practice in a way that makes results naturally and routinely visible to all the stakeholders, i.e., practitioners, patients, and purchasers. An intentional society might well require that patients and practitioners attach as much importance to the care of health as they do to the care of disease while measuring the outcomes for both.

Minnesota Department of Health:

As noted earlier, it has been left to the commissioner of the Department of Health to adopt rules necessary to implement, administer, or enforce the provisions of State Statute 146A. They continue to believe that creative alternatives to regulatory approaches should be sought where possible. At this point in time no rules have been adopted. Further, they

do not wish to develop or set standards for CAM practitioners. However, they will watch the experience of the unlicensed CAM providers and seek legislation if they become concerned.

The Pew Health Professions Commission:^{10,11}

The Task Force on Healthcare Workforce Regulation surfaced a number of concerns, including the lack of uniformity in language among the states and the professionals which has had the effect of creating barriers to high quality health care as well as confusing regulators, legislators, professionals, and the public. They recommend that “scopes of practice” be eliminated because they draw boundaries among professions which create exclusive domains of control over the delivery of specific services. They articulated a number of principles for the healthcare workforce, regulatory system. These include the following: promoting effective health outcomes, protecting the public from harm, holding regulatory bodies accountable to the public, respecting consumers’ right to choose their health care providers, encouraging a flexible, rational and cost effective health care system that allows effective working relationships among health care providers, and facilitating professional and geographic mobility.

In light of the earlier discussion on Intentional Law, one could visualize how intentional logic could address these concerns while promoting the development of a positive and enhancing environment, and ultimately the pursuit of well being. Since the nature of a health care system will have an 80 percent effect on the behavior of its practitioners, this is not trivial, but quite germane to the behavior of medical practitioners as they attempt to refer and integrate with CAM providers.

Assessment of Liability:

The bottom line of all of these ideas turns out to be personal, professional, legal, social, and economic liability. The stated intent by all has been consumer protection, even though we are now aware that some of our methods have been ill advised. We know this because we are developing many new technologies that will improve the performance of both practitioners and patients.

Whether licensed, regulated, certified, registered, inspected or not, the use of informed consent that goes deep into the relationships of health care is the most significant message of this paper. It speaks to consumer protection, comprehensive care, quality of care, and customization of care. At the same time, it addresses liability in all of its forms. In the end, all malpractice insurers, state and national, would be likely to support this conclusion.

Another conclusion relates to the large effect of a system (80 percent) on the behavior of its personnel. The health care system probably needs redesign, but in the meantime, its effect needs to be factored into these discussions.

A Medical Practitioner Advisory:

This section will summarize the content of this paper into some specific practical directives. They are as follows:

- 1) Ask your patient wishing to see a CAM provider to supply you with the information from the Client Bill of Rights. Also ask the patient to answer the questions of Exhibit B.
- 2) Practice Informed Consent
 - a. By means of negotiated consensus with both your patient and the CAM provider.
 - b. By developing a therapeutically competent relationship with your patient and the CAM provider.
 - c. Complete the questions of Exhibit A
- 3) Don't refer if your relationship to a CAM provider is deemed therapeutically inadequate.
- 4) Consult with personnel at the Minnesota Department of Health regarding
 - a. Health care policy for troubling cases
 - b. Clearinghouse information
- 5) Develop colleague relationships at the University of Minnesota, Center for Spirituality and Healing for information on published literature and current research.
- 6) Obtain a subscription to a periodic, peer reviewed journal of CAM medicine.
- 7) Seek ways that your local health care system, i.e., your own practice, could be intentionally accountable. For example, seek measures of patient satisfaction, develop a complaint committee made up of patients, use before and after health status measures, develop a risk registry for follow-up and continuity, read the literature on process improvement programs by Edwards Deming, and read the literature on customization of health care by Boynton, Victor and Pine.

Respectfully submitted,



Milton H. Seifert, Jr., MD
License No. 14736

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Exhibit A

**Negotiated Informed Consent:
Medical Practitioner Referring to a CAM practitioner
December 2000**

Note: These are questions a practitioner should answer prior to a discussion with a patient requesting a CAM referral.

Name of CAM provider: _____

Circle one:

I am able to verify the scientific basis underlying therapy of this CAM provider. Yes No

I am able to provide data on the effectiveness of the therapy of this CAM provider. Yes No

I am able to provide data on the safety of the therapy of this CAM provider. Yes No

I have a colleague relationship (a history of professionally working together) with this CAM provider. Yes No

I have met this CAM provider in person. Yes No

I, or a member of my family, has been a patient of this CAM provider. Yes No

I can give you the name of someone who knows this CAM provider. Yes No

If yes, name of person: _____

Note: All health care is done in relationships and the quality of that relationship will determine the quality of the outcome. A good relationship is characterized by listening, caring and mutual trust. There is also a high degree of willingness and intention to make the relationship work.

Exhibit B

Negotiated Informed Consent:
Patient Requesting Referral to a CAM Practitioner
December 2000

Note: These are questions a patient should answer prior to a discussion with your doctor regarding a CAM referral (CAM means complementary and alternative medicine).

Name of CAM provider: _____

Circle One:

I am able to verify the science, safety and effectiveness of this CAM provider.

Yes No

I plan to trust my doctor for these answers.

Yes No

I plan to trust _____ for these answers.

Yes No

I have met this CAM provider in person.

Yes No

I know a family member who has been to this CAM provider.

Yes No

I know how I will protect myself.

Yes No

Note: All health care is done in relationships and the quality of that relationship will determine the quality of the outcome. A good relationship is characterized by listening, caring and mutual trust. There is also a high degree of willingness and intention to make the relationship work.

Accountability Vs. Regulation

A practitioners approach to a key issue in redesign of health care delivery

by Milton H. Seifert, Jr., M.D.

Many years ago at the Education Committee of the Minnesota Academy of Family Physicians, we found ourselves learning how to design educational offerings for the membership. Our mentors at the time taught us that educational programs with the power to change behavior were preferred to all others. At about the same time, Paul Ellwood and his colleagues came to a consensus that *effectiveness* (i.e. a quality result) was a key ingredient in health system design. Similarly in 1978, the Institute of Medicine, after studying all of the known models of primary care worldwide, was able to list the principle elements of primary care, and one of these was accountability. Thus, it appears that a key component of a health care system has been variously expressed as behavior change, effectiveness, and accountability; and more recently, we have been calling the same component, outcomes measurement and management.

The Grounded Approach

Another useful way to think about educational design as well as health system design, is from the ground up. That means being thoroughly familiar with the basics, building a sturdy foundation, and having a lot of experience with practical application. As physicians, our training and experience teaches us to do the same thing so that we are able to find out what is really wrong with a patient. We want the diagnosis to be as accurate as possible so that the treatment can be as appropriate as possible.

The makers of Dove soap and Naprosyn have their own ways of getting to the basics, and one of the

most useful is the focus group. Many of us have been participants. In any case, it is a good place to ferret out the truth and the real issues, and this leads to better marketing and hopefully more truthful marketing.

The scientist in us might feel ready to dismiss this kind of research, but if it is used to understand patient needs and if the information is used to improve our product, than services and marketing are both better and everybody wins.

In fact, there is a scientific method known as the *Grounded Theory Approach* where the investigator gets directly involved in the phenomenon that is being studied pretty much like an intern or an extern. This method allows one to see the nuance, the interplay, and the reality of what is being studied. This research is useful in itself, and it can also lead to follow-up research that is more quantitative, more objective, and more compelling.

What do you think those who use the grounded approach find most useful? They find the stories of people to be most useful -- the details of what made it better, what made it worse, how they coped, and what is the overall meaning. As you can see, it begins to sound a lot like the work of a practicing physician. It is also easy to see the more grounded we are, the more effective and accountable we will be.

The Comprehensive Component

As suggested above, most of us who spend our professional lives in medical care have participated in the "grounded approach", because that is what we do. Alexander Flexner recognized this back in 1925 when he

said the mindset of clinicians solving the problems of their patients was pretty much identical to that of a research investigator.

Medical school prepared us to diagnose biochemical disorders, to seek out pathology, to repair trauma, to save lives, and to stamp out disease. That is one part, and it is the part most helped by the biomedical model. But when we became practitioners we learned there is another part. We learned how important the family, the job, the community, the church, and the economics are to the health and well-being of our patients.

We came to understand the psychosocial component of health and were amazed at how differently our individual patients handled stress and pain. Pharmaceuticals, procedures, and surgery (the tools of the biomedical model) were found to be much less useful with this set of problems. Instead, we learned to take an educational approach to teach about the use of support, humor, acceptance, forgiveness, willingness, and coping in general. Once again, the more comprehensive we became, the more effective and accountable we came to be.

With all of this in mind one wonders why these principles (accountability, comprehensive care, a grounded approach, and the integration of biomedical and psychosocial care) are not the basis of all proposals for current health care reform. Some of us think the debate is moving away from these principles, and others think the debate may be about other things such as power, control, money, special interests, and politics.

Intentional Accountability

There is a big difference between being accountable and being regulated. As physicians, we want to be accountable, not regulated. We want there to be system-wide accountability rather than a system-wide regulation and the bureaucracy that would go with it. But before we could get anyone to let us be accountable, we would have to show that we could be trusted and that we also had the means to prove it.

Regulatory pressures often force the physician to squeeze people into categories that are judgmental, pejorative, and even rejecting. These pressures also erode the process of careful, focused listening that comprises the heart of the doctor-patient encounter. We are slowly losing the healing power of the doctor-patient relationship which lies in the value patients derive from telling their stories to someone they trust as a healer. The inhibitory, controlling, regulating, and even punitive characteristics of the present governance system--reflects some outdated thinking.

“There is a big difference between being accountable and being regulated.”

There are many models much better than this. For example, the early Native Americans formed confederacies and local systems of governance that promoted participative democracy, respect for individualism, and a harmonious relationship with the environment. Another model is the Deming method of replacing Quality by inspection with Quality by design. This promotes better quality, more teamwork, and higher self-esteem. When these items are combined with measurement, they create intentional accountability.

One can only conclude that the governance of our medical care system is among the most antiquated. This is

the heart of the hurt for the principal stakeholders, namely practitioners, patients, and purchasers.

Accountable Cost Control

Health care costs have been cited as the most compelling reason for fixing the health care system by those who would reform it. Here again, we can choose between intentional accountability or inspection and regulation. Certainly, when our health care system is compared with other countries, we lose by those comparisons.

Barbara Starfield of Johns-Hopkins University did a study of the 10 western industrialized countries, including the United States, and compared them as to level of primary care, level of health status, and the ratio of satisfaction/expense. It turned out that the countries with the highest level of primary care also had the highest level of health status. The United States was the lowest in all three categories and the highest on expense.

If one were to take a grounded approach and visualize for a moment how health care is manufactured, one would see that this begins in a general medical practice, in little rooms with a couple of participants, negotiating the diagnosis and treatment for this particular episode of illness. It may lead to a referral, a procedure or surgery and when one added up the results of all those individual interactions across the country, that would be the output of our health care system for that day. Adding up the costs for those interactions would be the cost of the system for that day.

This would mean that health care is manufactured mainly within the practitioner-patient relationship. It would also mean that the practitioner and patient were in the best position to be intentionally accountable for the control of health care costs. The more they, by intention, did it right the first time, the less expensive it would be.

These two individuals would be guided by the basic principles of primary care. If they were not, it would be more costly. Here is why:

- **Accessibility.** Lack of accessibility leads to untreated illness, delayed diagnoses, and increased costs.
- **Comprehensiveness.** The lack of comprehensiveness leads to fragmented, incomplete forms of treatment and increased costs.
- **Coordination.** A lack of coordination leads to an incomplete or improper mix of services, inefficiency, and increased costs.
- **Continuity.** A lack of continuity leads to a reduced ability to recognize and revise a failing program and also to increased costs. Transfer of care to another provider increases costs and decreases continuity.
- **Accountability.** Inability or unwillingness to measure and meet health care needs adequately, and to document that this is so, leads to governance by regulation and increased costs.

The Values Framework

Some voices in health care reform have urged us to be accountable for an explicit, defensible, agreed-upon framework of values that will help us evaluate reform proposals and establish criteria for assessing the efficacy of our health care system. If we are willing to be accountable for social values, it would seem that we need to do the following:

1. Reprioritize certain essential values, such as providing fair access.
2. Reinstate neglected ones, such as meeting the needs of underserved populations.
3. Add needed ones, such as promoting personal responsibility and social advocacy.
4. Rearrange others, especially those that conflict with each other.

Reinhard Priester, J.D., Center for Biomedical Ethics, University of Minnesota, has identified and defined five essential values that might guide the restructuring and reform of our health care system. They are as follows: fair access; quality;

efficiency; respect for patients; patient advocacy. In addition, the center has defined six other instrumental values that support the essential values: personal responsibility; social solidarity; social advocacy; provider autonomy; consumer sovereignty; personal security.

One would be hard pressed not to include these criteria in proposals for health care reform. However, adoption will require even further accountability.

System Reform Through Practice Design

Some of us think that practitioners and patients, if they could be heard, would contribute the most to meaningful reform. If patients had successfully participated in their own medical care and had a voice in how their primary care medical practice was managed, then no doubt they and their practitioners would have already constructed a working practice model by means of the ground-up approach. But, unfortunately, it is these voices that are the furthest from the debate and are very unlikely to be a part of the dialogue. So, what can we do if we want to have a voice?

Practitioners and patients could best join the dialogue by creating a workable practice design, characterized by collaboration and negotiation. Their combined and integrated voices would contribute to both practice management and patient care, and this would serve to educate and empower patients. When it became apparent that this is an attractive model, it would be duplicated and the practitioner/patient-voice would grow in other medical practices. There are further details, but the key to success is the understanding that this can be done with accountability, but not with regulation.

In the end, we would expect to see the development of a primary care practice model that avoids the mind-body dualism while meeting both the biomedical and psychosocial needs of patients integrated within the context of a strong practitioner-patient

partnership. The core policies, procedures, and programs would rest on the five basic principles of primary care, the defining characteristics of community-oriented primary care (COPC), a values framework, and the conceptual elements of family medicine. All of these would fully integrate with the health care system as a whole.

The model, through a consensus negotiation approach, would promote greater patient responsibility, enhance the competence of physicians, and improve patient satisfaction. It would use a teamwork approach to address emotional, social, and spiritual health problems within the practice setting and would apply the principles of both science and ethics to the basic primary care issues. It could be the foundation of our health care system.

"Since the reform process is mostly governmental, perhaps we should define the proper role of government."

Practice based clinicians will be glad to know there are practical strategies to put these ideas into operation. In recent years, the Rand Corporation and the New England Medical Center have made major advances in developing the necessary technology. Important Minnesota developers include the following: InterStudy; The Health Outcomes Institute; The Minnesota Department of Health; and the Management Medicine Foundation. Hardware, software, short form questionnaires, and information systems are becoming useful for clinicians and hold the promise that one could be an autonomous but accountable practitioner.

The Reform of Health Care Reform

Since the current reform process is mostly governmental, perhaps we

should define the proper role of government. The proper role of government is to stifle competition that is bad for its people; to facilitate the formation of structures, alliances, and services that are good for its people; to promote enlightened partnership management at all levels; and, most important, to manage the performance of those who do the performing.

The complimentary role of citizens is to perform well by intention and to have a data system that measures results. It will also require that we undertake change in our own personal health behavior in order to be fully accountable.

Summary

Accountability is the key to autonomy. It becomes easier to achieve the more we are willing to become intentional about it. The alternative to accountability is regulation which is inhibitory, inspectional, punitive, archaic and expensive. Good governance is possible with accountability while bad governance is probable with regulation. Regulation seeks the minimum acceptable standard while accountability seeks the highest possible standard. We want to see appropriate accountability for all levels of stakeholders and we want all levels to participate in developing the necessary policy. Finally, we want our health care system to operate with methods of accountability and information systems that will design and redesign health care delivery in a perpetual way.

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THE QUALITY LETTER *for Healthcare Leaders*[®]

Volume 9 Number 10 November 1997

On Addressing New Issues in Patient Care

"Health status assessment gives you insights on patients' psychosocial lives that are often swept under the rug or missed entirely."

Harry Wetzler, M.D.
Senior Vice President
Health Process Management Inc.

On Changing the Prevailing Model of Clinical Care

"Effectively integrating patient preferences into treatment requires a fundamental shift in the way we deliver healthcare."

Robert Nease Jr., Ph.D.
Assistant Professor of Medicine
Washington University Medical Center

Featured in This Issue: Health Status Assessment

QL Lead Story 2

Health Status Assessment — A Vital Sign for Planning Patient Therapy

To better understand patient problems, some physicians are gathering and evaluating data on patients' perceptions of their health and emotional strengths. The tool — the SF-36 or Health Status Questionnaire — can be incorporated into practice with a small investment in technology and a few minutes with the patient.

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Bringing Patient Preferences Into Decisionmaking

"Patient-specific preferences challenge preference-fixed guidelines," says Robert Nease Jr., Ph.D. He argues that rational decisionmaking must accommodate a patient's sense of what outcome would be best.

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Graphing Health Status Can Help Pinpoint Patient Problems

Learn the steps that practitioner Donald Lum, M.D., takes to review the results of a health status survey with each patient and plan the appropriate course of treatment.

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Carve-out Behavioral MCOs Look to Performance Standards, Accreditation to Counter Charges of Poor Quality

Sensitive to charges of inadequate care, managed behavioral care firms are searching for ways to become more accountable to the populations they serve.

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by Mary Darby

Health Status Assessment — A Vital Sign for Planning Patient Therapy

Patients' perceptions of their health status need to be weighed along with blood pressure and lab results to choose the best course of treatment, these physicians say. They're using health status surveys to get the information they need.

Milton Seifert Jr., M.D., a family practitioner in Excelsior, Minn., recalls the case of a 22-year-old man who came to see him for a seasonal allergy problem. Soon Dr. Seifert discovered that his patient had a host of other, potentially more serious problems, including work-related stress, alcohol abuse and smoking. He also learned that the man disliked his job intensely and often felt angry and depressed.

This information put the man's allergy symptoms in a new context, as a clearer and more comprehensive picture of his health emerged, Dr. Seifert says. "What I was looking at was the way he felt about life in general," he explains. "I told him, 'When you treat these other things, the allergy symptoms may not seem so bad.'" Dr. Seifert says he is trying to help the man solve his lifestyle problems.

How did Dr. Seifert become so attuned to his patient's inner life? The answer lies in his incorporation of health status assessment into his everyday clinical practice. Dr. Seifert routinely asks his patients to fill out a form called the SF-36 Health Survey (see box, page 3) and a health behavior survey he designed that includes questions on exercise, diet, sexual activity, work, seat belt use, safety and other lifestyle issues.

The two surveys, known collectively as the Health & Disease Questionnaire (HDQ), are loaded into a hand-held computer. Patients take a few minutes to enter their answers on the computer, and Dr. Seifert quickly scores them, so that when he sits down to talk with a patient, he has concise, "real-time" information. He also has a clearer picture of what is going on with his patients' health — which he can flesh out as needed during his consultations.

Such health status assessment — the use of standardized, patient-based surveys to obtain information about different aspects of health — is slowly moving into the mainstream of clinical practice. For some time, researchers have recognized the value of patient behaviors and perceptions in measuring and assessing clinical outcomes and quality of life. Now, a few physicians are going a step further — making health status assessment part of their practice routine and using survey-based information to improve care for individual patients. No

one really knows how widespread the practice is, but the peer-reviewed literature is an indicator. In the early 1990s, only six articles mentioned use of

BENEFITS OF HEALTH STATUS ASSESSMENT

A number of benefits accrue to practitioners using properly designed health status assessment techniques:

- ✓ Patient care is improved.
- ✓ Patients are able to participate more fully in disease management and health maintenance.
- ✓ Practitioners can help purchasers and business owners improve employee health and reduce costs.
- ✓ Practitioners acquire scientifically sound data useful in negotiations with other entities within the healthcare system.
- ✓ The technology is nonintrusive, preventing practitioner stress. The patient does the work.
- ✓ Healthcare and healthcare research merge into one process.
- ✓ The technology supports and improves the interaction of clinician and patient. This adds value to the service.

the SF-36; during 1996 and 1997, more than 100 articles on its clinical use were published.

This issue of THE QUALITY LETTER examines how a handful of physicians are using health status assessment to gain new insights into their patients' problems, communicate better with their patients, improve care and target their resources more efficiently. These physicians say that health status assessment has helped them bring their patients' needs and perspectives more fully into healthcare decisionmaking.

Viewing Care Through the Patient's Eyes

"We started out from a relatively skeptical point of view," recalls Klemens B. Meyer, M.D., director of dialysis services for Boston's New England Medical Center. Nephrologists spend a good deal of time with their patients, who generally come in several days a week for dialysis treatment. "We were very proud of giving personalized care to our patients, and we felt we knew our patients very well," Dr. Meyer says, adding that he and his colleagues expected the SF-36 results to merely reaffirm what they already knew intuitively. But that view changed after Dr. Meyer and his colleagues studied their experiences using the form among their dialysis patients.

For example, one patient felt he was doing significantly worse than did his physicians, who learned that they had greatly underestimated his disability during recovery after surgery to repair a fistula. Another patient perceived that he was doing better than his physicians did. It turned out that, unknown to his physicians, the patient had felt significantly impaired by hip pain. When the patient started taking ibuprofen on his own to relieve the pain, his overall view of his health improved substantially. "We had been attending to all sorts of things with great solicitude, but not the hip pain," Dr. Meyer notes.

Those and other experiences, Dr. Meyer says, illustrate that "there are a number of aspects of health that are hard to see through somebody else's eyes."

That is where generic health assessment surveys like the SF-36 come in. These instruments were designed to capture patients' perceptions of their health on a range of dimensions — systematically, effectively and efficiently.

Getting the Data Takes Only Minutes

Physicians applying health status assessment to patient care acknowledge its challenges, but they are not insurmountable. Generally, a standardized survey, such as the SF-36, is administered to a patient during an office visit. These surveys may be combined with disease-specific or other questions such as those Dr. Seifert developed. Patients can fill them out in a few minutes. The information may be processed through an optical scanner and

ABOUT THE SURVEY INSTRUMENTS

The SF-36 Health Survey is a multipurpose survey that yields an eight-scale health profile (see page 4), as well as summary measures. The SF-36 — which stands for short form, 36 questions — has been used to monitor general and specific populations, compare the relative burden of different diseases, assess health benefits produced by different treatments and screen individual patients. Permission to use the SF-36 is routinely granted royalty-free to individuals and organizations for their own use by the Medical Outcomes Trust.

The Health Status Questionnaire (HSQ) by the Health Outcomes Institute in Minneapolis adds three items that are disease-specific mental health measures to the 36-item form.

Another survey almost identical to the SF-36 is produced as the RAND 36-Item Health Survey; this less-often-used version recommends a different scoring method on two of the eight scales.

Information on the SF-36 is available on the World Wide Web at <http://www.sf-36.com>, or call the Medical Outcomes Trust at (617)426-4046. For information on the HSQ, call (612)858-9188. Information about the RAND 36 is available from RAND at (310)393-0411.

“If you get a graph of the scores and the two of you are looking at the graph and data trends, you can solve problems together and evaluate effectiveness of treatment.”

Dwana Bush, M.D.
Atlanta Family Medicine
Atlanta, Ga.

translated almost immediately by computer into graphs (see “Graphing Health Status Can Help Pinpoint Patient Problems,” pages 14–16) that illustrate a patient’s scores in eight health-related domains:

- Physical function
- Role limitations as a result of physical problems
- Role limitations as a result of emotional problems
- Bodily pain
- General health perceptions
- Vitality
- Social function
- General mental health

Practitioners with limited computer capabilities can send completed survey forms to a service vendor by fax or telephone using voice recognition technology; the vendor’s software computes the scores and transmits the results within minutes.

Low Scores Shed New Light on Problems

The choice of technology makes little difference, physicians say. What’s important is to have those scores available to share with patients during consultation. And that, they say, is when the real discovery process begins. By clarifying patients’ perceptions of the reasons for their low scores, physicians may unearth important information that places their patients’ problems in a whole new context for diagnosis or treatment, says Donald Lum, M.D., president of a consulting firm called Living Lab Inc.

SAMPLE HEALTH & DISEASE QUESTIONNAIRE RESULTS

Sample Category/Questions*	Analysis of a Negative Response	Level of Concern
Disease impact:		
Pain	Pain with moderate limitation	Advise help
Social functioning	Fair social functioning	Advise help
I’d be a lot healthier if life hadn’t been so unfair.	Spiritual health deficiency	Health hazard
I am willing to go to great lengths to improve my health.	Spiritual health deficiency	Health hazard
I minimize my intake of fats and oils.	Excess dietary fat	Health hazard
I am satisfied with my sleep pattern.	Dissatisfaction with sleep	Health hazard
I use a seat belt.	Seat belt deficiency	Mild concern
I have many financial worries.	Financial stress	Important problem

*Patient responds by indicating percentage of agreement on a scale.

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"I used to say health status assessment paints a word picture of the patient," says Dr. Lum, who's also a practicing family clinician at the Allina Medical Group's River Valley Clinic in Northfield, Minn. "My new analogy is that it's actually like the picture frame that surrounds a presenting complaint or chronic illness with the mind-body connections."

Advocates say they're learning to understand their patients more completely, more efficiently and more effectively. They warn that administering forms such as the SF-36 to patients is not a substitute for talking with them. It is a tool for engaging in more productive dialogues.

"In the old days, we'd ask, 'How are you doing?'" says allergist Don Bukstein, M.D., of the Dean Clinic in Madison, Wis. "Now we have a much broader ability to really say how that patient is doing beyond just overt symptoms. And if people don't think that asking patients is important, they're wrong, because patients' answers are very accurate and sometimes lead to important questions."

Dr. Seifert says that combining the SF-36 with the lifestyle survey he designed has helped him probe into health and disease as "two interdependent topics." The SF-36, he notes, is a "good measure of the impact of disease," but he also wanted to assess lifestyle habits related to patients' health. Together, he says, the two instruments have enabled him to "create a language of health negotiation" with his patients.

One of his cases involved a 32-year-old woman with Crohn's disease, who, despite significant health-related problems, put on a show of optimism. Using the SF-36, Dr. Seifert says he quickly discovered that she had a low health perception and low vitality. "She said she thought she was going to die," he recalls. Upon hearing that, Dr. Seifert arranged for a team of providers — an internist, a nutritionist, a digestive disease specialist and a health educator who teaches life management skills — to work with her and get her back on track. The test scores will be used to mark her progress.

Like Dr. Meyer, Dr. Seifert says he initially had low expectations regarding the usefulness of health status assessment. "I wasn't prepared to know that there could be that much improvement," he says. "We are finding the test results to be very reflective of our patients."

Start a Dialogue

Systematic use of the SF-36 has helped Dwana Bush, M.D., a family practitioner with Atlanta Family Medicine, involve her patients more in their own healthcare by identifying health-related goals and deciding on steps to achieve them. The SF-36 scores serve as a basis for discussion between patient and clinician. "A graph depicting a patient's current health status is the most important 'vital sign' for planning patient care," she notes. "If you get a graph of the scores and the two of you are looking at the graph and at data trends, you can solve problems together and evaluate effectiveness of treatment." For example, a patient with a low vitality score may reveal that

INTERPRETING HEALTH STATUS ASSESSMENT RESULTS

The real value of health status assessment data comes into play when the physician shares the results with his patient and uses the assessment as a basis for discussion and decisionmaking, notes Donald Lum, M.D., president of Living Lab Inc., Northfield, Minn. Dr. Lum outlines four steps in that process:

1. Explain the meaning of each measure to the patient.
2. Identify measures in which the patient scored low.
3. Ask clarifying questions to determine the patient's perceptions of the reasons behind those low scores.
4. Use this information in clinical decisionmaking.

"Assessment," notes Dr. Lum, "is an interactive process."

she is feeling stressed by work. A new objective emerges: to minimize that stress and its effects.

Dr. Bush says that use of the SF-36 also has heightened her awareness of depression among her patients. The survey's depression screen (less than 60% of the total possible score for mental health) flags potential problems. As a result, she has redesigned her care processes to evaluate and treat depression and other mental health problems in the daily course of primary care. Dr. Bush notes that diagnosis of depression is particularly important in treating patients with chronic diseases, such as diabetes or asthma.

MEDICARE DEMONSTRATION PROJECT COLLECTS HEALTH STATUS INFORMATION THROUGH OASIS

Medicare home care providers say a new, standardized outcomes data set is helping them identify functional and other problems their patients are experiencing and design appropriate care plans earlier.

"We're asking questions that we've never asked before, and in areas that we've never asked about before," says Kitty Horton, R.N., B.S., former assistant vice president of patient care services at the Twin County Home Health Agency in Galax, Va. "This gives you a better picture of what's happening with the patient, which is helpful in setting up services to better meet patients' needs."

Fifty home health agencies throughout the country have been involved in Medicare's demonstration project using the Outcome and Assessment Information Set (OASIS), which elicits information on some 80 health status items, including physical and cognitive functioning. OASIS was designed to measure outcomes of Medicare home care patients over time, until they are discharged from home care.

HCFA Proposes Use for All Medicare Home Care

Although the demonstration project is still under way, the Health Care Financing Administration has proposed implementing OASIS data collection as a condition of participating in Medicare home care — creating, in effect, a mandatory outcomes-based quality improvement program.

Home care providers who have been using OASIS say there is a significant learning curve. "The nurses were a little shell-shocked at first," recalls Barbara Harlow, R.N., manager of performance improvement and support services for Providence Home Health Care of Novi, Mich. But with time, she and Ms. Horton say, administration of OASIS has become a part of everyday care.

Ms. Harlow and Ms. Horton say that OASIS makes patient assessment more consistent, objective and comprehensive. "It forces you to ask more questions up front," says Ms. Harlow. In the past, home care nurses may have waited to establish rapport with their patients before asking them questions about depression, thoughts of suicide or hopelessness.

Now, these and other questions about health status are asked each new patient, then repeated every 56 to 60 days to recertify patients and again at discharge from home care.

"I think our nurses are aware much more quickly of their patients' needs," notes Ms. Harlow. "You can see very clearly in black and white how they're functioning."

Standardization Permits Benchmarking

Using a standardized system also allows agencies to benchmark their own performance against national averages. Agencies participating in the demonstration project have used OASIS to launch their own internal quality improvement initiatives too.

Twin County, for example, decided to focus on treatment of patients with shortness of breath, according to Ms. Horton. As a result, the agency stepped up staff education, examined how nurses were documenting and describing shortness of breath and started placing more emphasis on monitoring weight gain among at-risk patients. Ms. Harlow notes that use of OASIS showed that Providence was performing better than the national average in the areas of pain control and improvement in dyspnea but needed to work on ambulation.

Ms. Horton and Ms. Harlow advise other agencies that are gearing up for OASIS to start early and give themselves as much time as possible to prepare; it took them three months before the program was fully implemented. Internal office processes, policies and forms need to be revised and tested. Staff need to be trained on the purpose of OASIS and the new policies and processes. Staff should also talk with agencies that have participated in the demonstration project for insight into their experiences with OASIS, they add.

For more information about OASIS, contact Kathryn Crisler, M.S., R.N., assistant director at the Center for Health Services and Policy Research, University of Colorado, (303)756-8350, or the National Association for Home Care, (202)547-7424. Contact Ms. Harlow at (248)380-1200 and Ms. Horton at (800)719-7434.

The real payoff, physicians say, comes with time, after several rounds of scores have been compiled and patterns begin to emerge. "If your patient improves or deteriorates, you can do a process of discovery to find out what's making the difference either positively or negatively," explains Dr. Lum. In real life, he says, patients with complex problems often require a number of interventions, and figuring out which one made an impact can be difficult. For a patient with both depression and diabetes, a physician can use health status scores as a launching point to identify the relative effects of antidepressants, cognitive therapy, intensive insulin management and diet. "You will have your own perspectives about these things, and patients will have theirs," Dr. Lum says.

In addition, Dr. Bush notes that her use of routine health status assessment has helped her target her resources more efficiently. By zeroing in on patients' problems and responding to them earlier and more appropriately, she's reduced her use of diagnostic tests and referrals. She's been using the SF-36 for four years, and she can see patterns emerging and can quickly identify changes in a patient's status — and quickly respond.

Assessment Predicts Patient Use of Resources

Health status assessment can be extremely useful in managing risk, says John E. Ware Jr., Ph.D., senior scientist at the New England Medical Center's Health Assessment Laboratory and the principal architect of the SF-36. "A big part of managed care is risk management — deciding what a patient's care is going to cost, what her risks are and how she should be managed," he notes. "That's going to help with capitation a lot." Clinicians agree. Dr. Bush observes that patients who score low on the SF-36 tend to consume more healthcare resources. Dr. Bukstein says that scores are highly predictive of resource use among asthma patients. And Dr. Seifert notes that taking on intentional accountability buys clinicians reasonable and appropriate autonomy — which piques many practitioners' interest.

Dr. Bush has demonstrated in one managed care population that her patients' low initial mental health scores have, on the whole, improved by 20% — of interest to managed care administrators looking for quality outcomes documentation. "Functional health status measurement and identifying trends can get the patient, provider and purchaser all reading off the same page," she says.

Invest for Long-Term Gain

One nagging question remains: If health status assessment is so beneficial, why aren't more clinicians incorporating it into their practices?

Consultant Harry Wetzler, M.D., M.S.P.H., a senior vice president at Health Process Management Inc., Doylestown, Pa., and a clinical outcomes specialist with the American Medical Group Association, has several theories.

FOUR KEYS TO SUCCESS

- ✓ **Unwavering support from local administrators.** This support empowers the team to effectively implement new clinical care processes by clearing roadblocks, gaining access to resources and sponsoring a mandate for innovation and change.
- ✓ **Well-organized clinical teams.** Respected opinion leaders from multiple disciplines, they act strategically to embed clinical innovation into the everyday work processes at the site.
- ✓ **Strong clinical champions.** Highly respected by their peers for excellent clinical skills, they demonstrate a high degree of interest and competence in teaching new clinical skills to other clinicians.
- ✓ **Clinical mentors.** Successful dissemination of the skills to clinicians depends on effective mentoring and coaching.

First, he says, the clinical quality arena is crowded with activity. Many practices are caught up in efforts to keep up with accreditation requirements, contracting demands by managed care organizations and multiple pressures for data. In addition, health status assessment may seem vague to the uninitiated. "They're not sure what they can get out of this," Dr. Wetzler says. Chances are it won't be reimbursement.

Clinicians also may be afraid of addressing new issues that will cut into their productivity. "There's no question in my mind that health status assessment gives you insights on patients' psychosocial lives that are often swept under the rug or missed entirely," Dr. Wetzler asserts. "There's a disinclination to deal with these issues out of concern that 'If I touch this, I'm tied up for 30 minutes.'" That, he believes, stems from a misconception of what productivity means in healthcare delivery. "Right now, physicians think in terms of 'How many people can I see?' We feel that productivity should be equated with 'How much health am I producing?'"

Some physicians say they consider health status assessment neither time-consuming nor difficult. Others say that although health status assessment does require a little additional time up front, it generally saves time down the road by helping them to focus on important problems early and prioritize treatment. "It is a time investment, but it is time-efficient," claims Dr. Lum.

Overcome Barriers to Implementation

But even staunch supporters of health status assessment in clinical practice say there are some nuances to it.

Dr. Lum led a collaborative group practice project in the Allina Health System that centered on health status assessment. Of seven sites that started with the project, only three completed it. Dr. Lum says those practices shared three characteristics: strong clinical champions, well-organized clinical teams and unwavering support from local administrators. "At the micro level, those three things are probably the most important transformation drivers," he notes. As a corollary, he recommends heavy emphasis on clinical mentoring and coaching for successful dissemination of the skills to clinicians. (Dr. Bush, he notes, was his clinical mentor.)

Dr. Meyer agrees with Dr. Lum about the need to train and educate physicians in health status assessment. "We're not taught how to interpret a change in physical functioning or in role limitations due to physical problems," he observes. "It takes some figuring out."

Explaining to clinicians what they should do with the results can be tricky. These practitioners offer four key steps to successful application:

EDUCATIONAL SERIES AVAILABLE ON HEALTH OUTCOMES SURVEYS

A new educational video series offers a primer on patient-based health outcomes surveys and their uses. The series, called *Understanding Health Outcomes*, is accredited for physicians, nurses and pharmacists by Tufts University School of Medicine and is designed for clinicians, hospital and managed care administrators, healthcare policy-makers, employers, researchers and students of outcomes research.

Each program includes interviews with experts, examples of applications and graphics on specific teaching objectives. Each program consists of a videotape, study guide and diskette. Three of nine tapes for the first part of the series, "Health Status: Concepts, Measures and Applications," have been completed. Parts two and three will be developed and released in 1998; the others are in production. The second part of the series will focus on the use of patient-based measures for specific diseases, such as asthma, depression, migraine, dementia and sleep disorders. The third part will demonstrate how specific treatments affect patients' functional health status.

The series is being produced by HealthStat Productions Inc., with sponsorship by Searle, Glaxo Wellcome Inc. and Janssen Pharmaceutica. John E. Ware Jr., Ph.D., director of the Health Assessment Laboratory at the New England Medical Center, is chief scientific advisor for the series.

The tapes are being offered for sale individually or by subscription. The initial overview program is \$95; programs in Series I, including the nine tapes, are \$250 each. Subscriptions are also available for \$1,350 (a 35% discount).

For information, contact Ken Nochinson of HealthStat at (732)636-6930; e-mail: HStatProd@aol.com.

❶ **Start small.** "Don't try to do too much too quickly," Dr. Wetzler says. Keep in mind the impact of assessment on staff, and don't lose sight of the fact that some financial investments are necessary. "Costs here don't have to be extraordinary, but you can't do it on a shoestring either," he warns.

❷ **Be prepared to process the data.** Technical needs can run the gamut. Dr. Meyer says at first it was a matter of remembering to have enough pencils for his patients to fill out their forms. Others describe their experiences with different types of scanners, computer programs and fax services. Dr. Bush says she believes that many people expend too much angst on high-tech hardware. "I tell people to invest in a little laptop that they can take around to process graphs on site," she says. Dr. Wetzler believes that technology — especially in the outpatient arena — needs more integration. "You want to automate this as much as possible by tying it in with appointment and billing systems," he notes.

Dr. Ware is upbeat about technology. The development of phone/faxback, computer, Integrated Voice Response and Internet technologies, which are currently being merged with television, he notes, has made seamless use of health status tools in practice "much more feasible." And some two dozen vendors now have software to process the forms.

❸ **Put referral systems in place to support needed actions.** Dr. Bush's experience with depression in patients is a case in point. "We found that approximately 30% of our patients have low mental health scores, which suggests that they need to be further evaluated for depression," she says. "You need to have an algorithm to follow for treatment and monitoring — and deal with the condition without creating a traffic jam." Referral systems need to be in place. "You need to have an individual and systemwide approach to dealing with mental health scores," Dr. Bush asserts.

Dr. Bush notes that "people tend to overmeasure and underrespond. You don't want to document that 30% of your patients have low mental health scores and then be unprepared to respond."

❹ **Verify and understand the results.** This interaction with patients "is the first thing you do," Dr. Meyer says. That means talking to patients and probing beneath the surface. Even then, "whether you do something about it depends on the information," he adds.

Dr. Ware is optimistic about the future of health status assessment in clinical practice. "We're on the verge of a whole new generation of tools," he predicts. The reliability and sensitivity of the instruments will improve and they will become even cheaper to use than they are now; a number of firms are marketing their assessment services for a few dollars or less.

Training programs in incorporating health status assessment into practice are also being developed, including the educational series produced by HealthStat Productions (see box, page 8) and a twice-yearly conference sponsored by the Integrative Health Institute in Atlanta.

"The real challenge is going to be: Who knows what to do with outcomes data and has the will to do it?" Dr. Ware says. ♦

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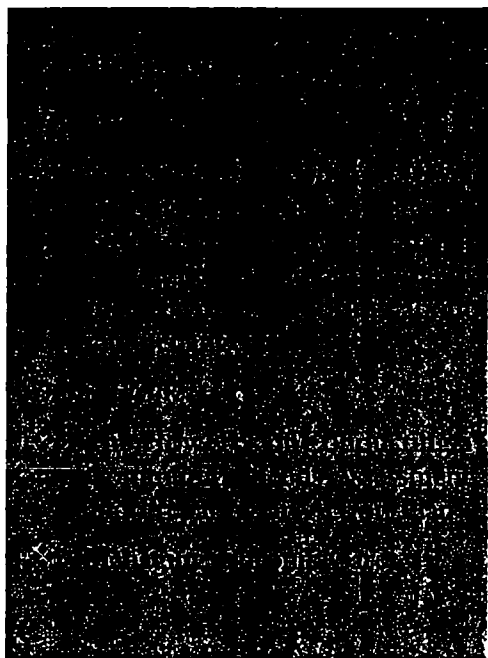
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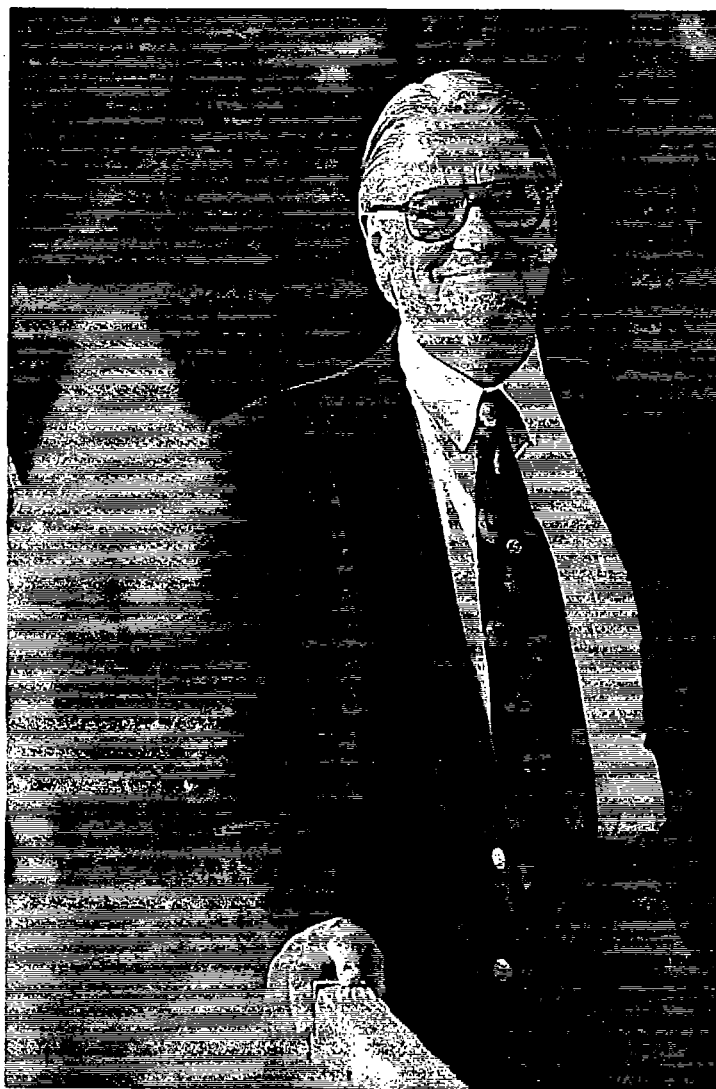
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Could better care beat managed care?

This FP has bet his career that it can, though the odds are against him. His patients proclaim him the best doctor around.



FP Milton Selfert Jr. lets a patient advisory council guide his practice, including the setting of fees.

By Ken Terry
SENIOR EDITOR

Excel­sior, Minn., a suburb of Minneapolis, is the birthplace of the effort to make HMOs a major force in American medicine—and home to a medical practice of a kind that could make managed care obsolete.

For a quarter of a century, Excel­sior FP Mil­ton Seifert Jr. has been practicing a holistic brand of medicine that he calls “comprehen­sive care.” It involves both traditional medicine and “health educators” who offer psychological counseling as part of the primary-care process. It recognizes the patient as a full partner in diagnosis and treatment. And, if many of Seifert’s patients and an HMO survey can be believed, it’s an approach that’s highly conducive to patient satisfaction (see page 183).

While this system seems like the antithesis of assembly-line managed care, it grew out of the same impulse that gave rise to health maintenance organizations. Back in the mid-60s, Seifert, Paul M. Ellwood Jr., and four other health-care professionals coined the term HMO, to describe the prepaid concept that had been around for decades. As Ellwood and his group saw them, HMOs were the solution to America’s health-care problems at the time. They were supposed to provide accessible, comprehensive, continuous, and effective care. Although they’ve fallen far short of those goals, Seifert says, he has tried to achieve them in his own practice. He’s also strived to individualize care and make his practice accountable to the community.

In 1972, he made his commitment real by

forming his first patient advisory council. Now 50 members strong, the PAC deals with patient complaints, helps formulate practice policies, and advises Seifert and his two associates on business decisions (see page 184). It even decides how much the three family physicians can charge their 12,000 patients. During the past two decades, Seifert says, his basic office-visit charge has risen from \$15 to \$42, about average for the community.

While Seifert's Eagle Medical practice has struggled to survive financially, he attributes this mainly to external factors,

Where Seifert is out in front of the managed-care curve is in his emphasis on dealing with patients' psychosocial problems and measuring their functional health status.

rather than to the PAC. He views the PAC not as a limit on his freedom, but as a rock of support in a community that has depended on him and his family since the 1930s, when Milton Seifert Sr. began the clinic.

Not surprisingly, Milt Jr. knows his patients well. While chatting with one young woman, for example, he remembers when her father was nearly run over by his own tractor. And, pointing to a batch of family-photo Christmas cards tacked to his office wall, he says proudly, "I delivered at least 13 of those babies."

That connectedness with his patients has been the foundation of Seifert's approach all along. As his partner Steve Kind notes, "In a sense, it's a throwback, and in another sense, it's out in front of things a little bit. It's a modern reinterpretation of what the old-time family doctor used to be about."

Experimenting with functional status

Where Seifert is "out in front" of the managed-care curve is in his emphasis on dealing with his patients' psychosocial problems and measuring their functional health status. (This outcomes measure looks at how patients feel and function before, during, and after treatment.) He has been employing the most widely used health-status survey, the SF-36, for three years. He combines this with additional questions on "life-management skills," including health behavior (smoking, alcohol use, diet, stress, and exercise) and other problem indicators (unsafe sex, harmful drug use, difficulties with marriage and work, etc.). Seifert uses this "Health & Disease Questionnaire" to identify problems, break down barriers to compliance, and track outcomes.

In this respect, Seifert is far ahead of most other primary-care doctors and right in synch with employers that are starting to view functional status as the key to measuring quality in health care.* With the help of a consultant, Seifert is developing software to analyze the results of his questionnaire. He hopes to sell employers on the idea and to begin using the survey in treating the 10 to 20 percent of employees who ring up the lion's share of health-care costs.

If he succeeds, he believes, he'll be pointing the way toward a new method of direct contracting between employers and physicians. In place of fee-for-service, Seifert envisions a system of "fee-for-results," in which outcomes will replace services as the basis of physician compensation. And in place of health plans, which he sees as bureaucratic middlemen with no real stake in patient health, he wants to form grassroots networks of small practices governed by PACs.

If this sounds like the late-night ruminations of a country doctor who's been in the trenches too long, consider this: The Minnesota Academy of Family Physicians named

*See "Can functional-status surveys improve your care?" Aug. 12, 1996.

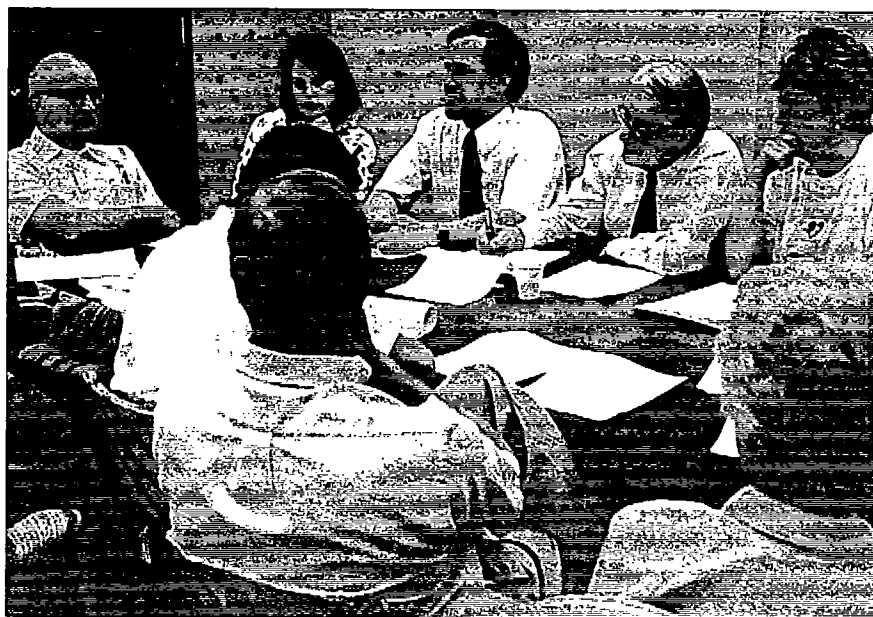
Seifert Family Physician of the Year in 1990. He's a full clinical professor at the University of Minnesota. He has published a book, appeared on the "Today" show, and spoken at national conferences. Top academics like Barbara Starfield of Johns Hopkins and Arthur Caplan of the University of Pennsylvania sing his praises.

"What Milton's striving for is a way to make primary care user-friendly," says Caplan, director of Penn's Center for Bioethics. "That's a crucially important thing to be doing, not just because it's the right thing to do, but because when you do it, you'll get better results."

Few physicians have followed Seifert's lead, partly because the health-care market doesn't reward doctors for practicing that way. In fact, economic pressures may force this pioneering physician and his associates—Steve Kind and Milt's brother Greg—to break up their practice. But doctors in St. Paul, Minn., and Atlanta are applying his ideas, and he's influenced others through his teaching activities.

Is modern health care ready for Milton Seifert Jr.? That's hard to say. On the one hand, payers are ever more determined to cut costs, especially for mental health care, and health plans are pressuring doctors to process patients as quickly and efficiently as possible. On the other hand, there's an increasing recognition that the unmet psychosocial needs of many patients may be increasing their utilization of medical services. As a result, some HMOs are trying to integrate primary care with psychological counseling.*

*See "Will health plans make you play psychiatrist?" July 15, 1996.



At a meeting of his patient advisory council, Seifert listens to members express their concerns.

The time may be right for Seifert's grand scheme, after all. But whether it is or isn't, you can learn something from the extraordinary lengths to which he goes to serve his patients.

Negotiating care with patients

In explaining his approach to patients, Seifert uses a diagram in which lifestyle (unhealthy to healthy) is plotted against stage of disease (none to severe).

"When I see a new patient," Seifert says, "I'll show him the diagram and say, 'I'm totally dependent on you for my competence.' He'll say, 'Well, aren't you a doctor?' And I'll say, 'Yes, but I need you to have an independent role.'"

Seifert prefers to "negotiate" diagnoses and interventions with patients, rather than prescribe treatment. While this approach may not always help the patient right away, he maintains that it increases compliance in the long run.

Seifert stresses the importance of learning from difficult patients rather than ignoring their problems. "If a patient says the only

medicine that's helped him is a controlled substance, most doctors will dismiss his complaints because he's an addict," he notes. "By assuming the patient's at fault, you cut off your capacity to do anything about his problem."

According to the Department of Health and Human Services, says Seifert, lifestyle accounts for about half of the mortality from the 10 leading causes of death. That's one reason he feels physicians should pay more attention to what patients say, and not just to their clinical symptoms. Whereas most physicians identify only 5 to 10 per-

"Doctors don't have time to talk with people for an hour about the stress in their life," says counselor Leigh Ostrander. "And it's very frustrating for doctors when they can't."

cent of patient problems as psychosocial, Seifert figures the real percentage is about 20 percent.

Like some other doctors and researchers, he's also noticed that stress can cause physical symptoms. He recalls one patient with pancreatitis, for instance, whose serum amylase level shot up whenever he became anxious. "We got to where we could recognize it early, before he got sick. In his case, stress was directly related to the recurrence of the pancreatitis."

Based on a patient's answers to Seifert's Health & Disease Questionnaire or his oral questions, the physician draws up a "problem list" that focuses on the patient's view of his health needs. Then he and the patient decide which problems to attack first.

So far, Seifert has given this survey to 300 patients when they came in for physical exams. Over time, he hopes to administer it to all of his patients. The biggest limitation

right now, he notes, is that the data have to be entered into his computer manually.

Making counseling part of primary care

If a patient clearly needs help managing his life, Seifert will refer him to one of the two part-time health educators in the office. Until recently, they were practice employees. They were dropped from Eagle's payroll a year ago because of problems with insurance reimbursement. While the two, who both have master's degrees, now work for a mental health clinic, they still take Eagle patients on a private-pay basis. If patients are diagnosed with a definable mental illness, such as depression or panic disorder, insurance may pay for the counseling (see page 186).

The health educators help patients with a wide spectrum of problems, ranging from stress and depression to marital and job conflicts, family crises, and alcohol and substance abuse. Typically, they see a patient for no more than five to 10 sessions. If the patient needs additional help, the counselors will refer him to a psychiatrist or other mental health professional.

What's different about the Eagle approach, says health coordinator Leigh Ostrander, is that the psychological counseling grows out of the patient's relationship with his primary-care physician. "Also, we meet people in the doctor's office," she says. "So they feel safe. They've been here. It's not like sending them out to a specialist. And in some ways, we're an extension of the doctor, the way a nurse might be."

Health educators can take a burden off physicians, she adds. "Doctors don't have time to sit down and talk with people for an hour about the stress in their life," she says. "And it's very frustrating for doctors when they can't. I think they feel overwhelmed, to walk out of a room when they know someone's in pain."

FP David Ness, who used to work with Seifert and is now part of a five-doctor group in St. Paul, says that his own prac-

tice's health educator offers a great resource for "difficult patients and people who need short-term counseling or help changing behavioral patterns. I tell patients: 'We treat this kind of problem as we treat any other medical problem. I'll be monitoring your progress, and the health educator will be helping you on an ongoing basis.' That's very reassuring, and it's non-threatening because patients don't have to go across town to some psychologist or psychiatrist.

"Milt's system saves you a ton of time. You need to identify emotional and mental health issues that people have. But you don't have to be the psychotherapist who deals with them. Before we had a health educator, if you got into those issues, you might be looking at an hour-long discussion. But now I can take care of those issues in a 15-minute office visit."

Seeing fewer patients and earning less

For Seifert, however, many visits do last an hour or more. In some cases, he says, it's because he attracts difficult patients and often "cleans up" after other physicians who don't want to deal with them. In addition, his low-key, approachable style encourages people to tell him their life stories. And he likes to do some counseling himself.

The upshot is that he sees only about 10 patients a day, half the number that his partner Steve Kind does. Of those, a third are there for level-4 or level-5 visits. So even though his approach may save money in the long run, Seifert himself isn't well-compensated for his work.

Last year, under his practice's income-distribution arrangement, which is based 75 percent on productivity, Seifert drew a salary of \$36,960. (He wasn't paid anything for his work in running the practice.) Greg Seifert, who pays less attention to non-medical

What patients say about Seifert

Patients of Milton Seifert Jr. and his two associates, Steve Kind and Greg Seifert, are more satisfied than those in the average family practice, according to a recent Gallup survey of 1,000 doctors commissioned by Minneapolis' Medica health plan.

Seifert himself scored 4.36 overall, compared with a mean of 4.05 for all FPs in the survey. Sixty percent of the Excelsior, Minn., doctor's patients rated his care as excellent, the highest rating on a scale of 1 to 5. That compares with 36 percent for other FPs.

Translating these statistics into words, here's a smattering of remarks at a recent meeting of the practice's patient advisory council:

"I don't feel like just a patient, but more like a friend. Milt stresses the whole person, including your emotional and spiritual aspects, and all those are important aspects of health."

"Milt has always said, 'The patient knows more than the doctor does, because it's her body, and it's his job to listen well and form a wise diagnosis.'"

"I've never felt talked down to by Milt. All the care I've received from him has been negotiated care. We lay all our cards on the table and figure out what our next step is going to be."

"It's worth fighting to preserve this kind of treatment. It's a dying breed in this age of corporatized and impersonal medicine."

One patient recalled what happened when her husband died a year and a half ago. "I was impressed because Milt called me. And he talked about what the implications of my husband's early death could be for my three sons. It was important to him."

Another patient said she felt she could be anywhere in the world and call Milt about her problems. "He'll even take my collect calls."

A patient who owns a local restaurant said of Seifert: "I'm 40 years old, and his father delivered me, and I've been coming here ever since. I've been really happy." While Seifert treats specific medical problems very well, she added, he's also someone she can confide in. In fact, she and her husband came to Seifert when they were wondering whether they should have children.

Patients also say they like the fact that Seifert never makes them feel rushed. With most doctors, says one, "you just pull your number out and wait your turn, and you've got your allotted 15 or 20 minutes and you're out the door. It's nice to have a doctor who will take an hour and a half if you have two pages of questions. If you can't ask your family doctor, there's not a whole lot of other people you can talk to."

How this practice listens to patients

When Seifert started his patient advisory council in 1972, he viewed it as a kind of advisory board that would take up patient grievances and give him feedback on how he was running his practice. He also wanted to convince patients that he was on their side and was dedicated to promoting their health. So he decided to open his books to the PAC and seek its approval for his financial and policy decisions.

At the outset, Seifert sent postcards to all his patients, inviting them to join the PAC. Of the 200 people who responded, about 50 attended the council's first meeting, and that many still belong to the group.

About 15 PAC members turned out for a recent meeting. Several patients said they'd been PAC members for many years, but there were also a couple of new faces, according to Seifert.

The doctor says he typically recruits new members during office visits. "When they start beefing about health care," he says, "I'll ask them, 'You want to

help us manage our practice? Join our council.'"

When a patient airs a complaint about the practice, the PAC acts as a mediator, presenting both points of view and trying to work out the parties' differences. Sometimes this leads to a policy change, as in the case of the practice's waiting-time policy.

For several years, the staff has been instructed to tell patients when there will be a long wait. Staffers are also supposed to ask patients about other engagements and make the doctor aware of those as soon as possible. The PAC recently decided that physicians should keep the staff better informed of expected delays, and that staffers should call some patients to warn them of delays.

In 1994, the PAC approved a policy that has reduced the practice's problem with no-shows and late cancellations. No-show patients are now fined \$50 if they miss a physical, and \$25 for other missed appointments. The fines are \$35 and \$15, respectively, for late calls to cancel visits.

Ann Benson, Eagle's bookkeeper, estimates that

problems, earned \$50,333 for the same number of hours. And Steve Kind, who sees patients 33 hours a week and does more episodic care than Seifert, received \$52,600.

(By comparison, the doctors in Dave Ness' practice make \$90,000 to \$120,000 working 3.5 to 4 days a week and seeing about 20 patients a day. Ness believes the Eagle physicians make so much less because of their payer mix and manual billing system.)

To make ends meet, Milton Seifert works at a local urgent-care center after hours. Seeing four or five patients an hour for "straight acute/episodic care," he earns four times as much as he would for the same amount of time in his office.

Eagle has actually been worse off than it is now. In the early '80s, when Seifert was practicing solo, he lost 25 percent of his patients and half his income in the first wave of managed care. Many of those who stuck with him couldn't pay as much, had less insurance, and had more health prob-

lems than those who left.

Since then, the practice's finances have improved and its patient load has risen to an all-time high. Seifert attributes that partly to his reputation for counseling patients and partly to the appeal of Steve Kind, who joined the practice in 1987 and attracted many younger patients.

(Greg Seifert also has loyal patients who've known him for many years. But he divided his practice from his brother's in 1972, sold out to a local hospital in 1988, and left town a year later. He didn't return until late 1994 and still isn't a partner.)

Over the past several years, the practice has contracted with a host of health plans but has been plagued by demands for ever-deeper discounts, not only from HMOs and PPOs but also from indemnity insurers. In 1994, Seifert says, his fees were discounted 28 percent; in 1995, he had to give up 33 percent, collecting \$500,000 on charges of \$700,000. So far this year, discounts are aver-

this policy probably saved one appointment a day in the year after it was implemented. Not many people actually paid fines, she adds, because most offered some kind of excuse. But the no-show patients became aware that their negligent attitude was hurting the practice financially, she says.

The PAC has also endorsed practice policies on such issues as hospital services and billing, prescription refills, and protecting patients and health workers from transmission of HIV and hepatitis B.

The PAC has input into the practice's financial decisions through its support-services committee, which includes Eagle's accountant and business staff. It meets to discuss such matters as staff hiring and salaries, use of outside labs, collection activities, and the practice's financial health.

When the physicians want to raise their fees, they propose charges that are average for the community. Over the past 20 years, says Seifert, the PAC has approved six raises—all the doctors have asked for. It has never capped his salary, he says, although he

did follow its advice to take less out of the practice during one rough period.

The PAC also sponsored annual health fairs in Excelsior for 16 years, and it has found volunteers to help other patients with rides, light housekeeping, shopping, and respite care. Home-health-care agencies have taken over much of that, but the PAC still tries to plug holes in community support services.

One longtime Eagle staffer says she doesn't know whether the PAC has helped the practice run more efficiently. "It's hard, because the patients don't know all the circumstances that go into our decisions," she says.

On the other hand, bioethics professor Arthur Caplan of the University of Pennsylvania, who sat on the PAC when he worked in Minnesota, calls it "wonderful" and a refreshing contrast to what happens in most practices. "One of managed care's major flaws is that patients feel there's no accountability," he says. "They don't know who to go to if they don't like something."

aging 35 percent, he notes.

Meanwhile, Eagle's overhead has jumped to 70 percent from 60 percent a decade ago. Like many other physicians, Seifert blames managed care, which has forced the practice to hire three full-time-equivalent workers to replace the one bookkeeper it had before. (Altogether, the practice staff includes six full-time and four part-time employees.)

But he also admits that his own dedication to patients has driven up overhead. "I do a lot of level 5s, and episodic care is much more profitable," he says. "But the practice has to do a certain amount of comprehensive care."

His associates agree—to a limited extent. Greg Seifert rarely refers patients to a health educator, and Steve Kind, although he follows his partner's system in many respects, is dissatisfied with his own compensation. "This is really a fun practice," says Kind. "We do a lot of things well; patient care is really enjoyable here. But the financial side is a lit-

tle difficult—in part, because of this marketplace. We certainly make some sacrifices to be small and independent."

Kind recently decided to take a full-time position in an FP residency program at nearby Methodist Hospital. He'd like to continue practicing at Eagle as part of his teaching job. Meanwhile, the Seifert brothers are discussing the possibility of practicing separately under the Eagle umbrella.

Giving health plans what they want

Seifert says the economic squeeze by payers has created this threatening situation. Yet, ironically, the health plans seem to like what he's doing. "They want patient satisfaction, and that's where I do well for them," he says. Partly as a result, he notes, Medica and the Blue Plus PPO returned all of Eagle's withholds last year. The doctors received \$15,400 from Medica and \$22,400 from Blue Plus.

Another factor in the return of their with-

What a "health educator" does for this family practice

Leigh Ostrander, one of the health educators for Seifert's practice, has a master's degree in counseling psychology and is working toward a psychologist's license. She began counseling patients part time for Eagle Medical in 1983. She left to work full time for Southwest Family Services, a mental health clinic, after insurance companies stopped reimbursing for her services through Eagle in 1994.

Nevertheless, Ostrander is continuing to see five or six Eagle patients a week in addition to her regular job. Once she gets her license, she says, she'd like to return to the practice full time if she can be assured of enough business to support herself.

She sees her role at Eagle as more educational than diagnostic. Using a form of cognitive-behavioral therapy, she teaches people coping skills that may help prevent them from wrecking their health.

Her patients range from people with serious mental illnesses to those who are merely stressed out. She has also been able to help patients with identifiable physical ailments. A woman with migraine headaches, she says, had far fewer of them and less pain after she learned how to cope with her emotions.

The patients initially come to see Seifert. They don't know that their doctor is going to send them to a counselor. Take George (we've changed all patient names), a 44-year-old account executive for a commodity brokerage.

When he was having marital and job problems last year, he came to see Seifert because "I was at the end of my rope. I was fatigued and worn out and didn't know what to do. I've never felt that low before."

George just wanted Seifert to prescribe an antidepressant. He got what he was looking for, along with a suggestion that he set up an appointment with Ostrander. After hesitating for three months, George finally did. He visited her half a dozen times over 10 weeks, and now he's feeling much better.

He says that Ostrander helped him objectify emotions that he'd always tried to repress. Now, he says, "I can have one of these feelings and be analytical about it at the same time. There's something I can do with it, instead of just feeling it and not having anywhere for it to go. I can resolve it and go on."

Seifert referred another patient, Sarah, to Ostrander when she was having trouble dealing with the stress of caring for two young children and working under an abusive, alcoholic boss. Sarah says she didn't feel strange about seeing the counselor. "I knew it wouldn't be the kind of therapy where you talk about your mother. This was just about what was happening, and what I could do." What Ostrander taught her, she said, was how to say No to her boss "without being confrontational about it." Now, she says, her stomach is no longer upset all the time, she's embarked on an exercise program, and she's feeling better about herself.

holds was their low utilization, says Seifert, adding that this amazed the plans. "They said, 'Gee, you do a lot more referrals and yet you still have lower numbers.' They don't see that those two could be related—that we're doing better because we use consultants effectively," he points out.

Both Seifert and Ness claim that addressing their patients' psychosocial problems reduces the need for tests and procedures. For instance, Seifert notes, a referral to a

neurologist for a headache almost always leads to a CT scan; so if he doubts a patient's headache reflects a serious condition, he'll look at whether it might be related to a psychological problem. He also cites a patient who complained of severe stomach pains and nearly ended up having exploratory surgery for pancreatic cancer. Seifert headed this off at the last minute by urging the patient to get therapy for his repressed anger first. The patient did,

and his pain vanished.

Not that Seifert would discourage a patient from getting a necessary test or undergoing needed surgery. But if there's time to scrutinize the problem from another angle, he says, he'll suggest that.

While researchers at Kaiser Permanente and elsewhere have shown that comprehensive care reduces utilization, says Seifert, he himself has no hard evidence that it saves money. But he notes that it shouldn't be hard to track costs from billing data and compare them with the functional-status data he's amassing. Partly for that purpose, he's developing outcomes software with Minneapolis pediatrician and informatics specialist Gerald Werth.

Catering to employers with health-status data

That software would allow users to tabulate and analyze data from Seifert's Health & Disease Questionnaire. It could be used to break down the health status of a company's insured employees and dependents, and it could help doctors customize services to fit each patient, according to Werth.

Since large corporations are already looking into such a system on their own, Seifert and Werth are pitching their software to small and medium-sized companies. The basic idea is to identify employees with unhealthy lifestyles and help them change their behavior. Both employers and workers would benefit, and physicians would be rewarded accordingly.

"We'd take the 3 to 5 percent of workers who are the most difficult patients, and we'd change them" by using health counselors and rehab specialists, says Seifert. "This

would be a big boost to my practice, it would get me away from dependence on the health plans, and I'd have very satisfied business customers."

Eventually, he envisions a network of family practices held together by this information technology and contracting directly with payers. "Nobody would have to own us, and each physician would be free to encourage seat-belt use or smoking cessation in whatever way he wants."

Milton Seifert Jr. may never bring that vision to life. But to those who know him and his work, he's something of a saint. "He's truly a remarkable man, and I think that when the medical profession looks back, it will realize that," says FP Mary Tuohy, a former student of Seifert's who now works in a primary-care clinic in Stanley, Kan.

FP Dave Ness thinks Seifert has touched something very important

that shouldn't be ignored. "Health plans are way behind the curve in dealing with mental health issues," he says. "When you consider how much of what we see in primary care is emotional illness, ignoring 60 or 70 percent of those problems isn't very smart."

Seifert, who says he's had "nothing but success" with his approach since 1972, is convinced it will outlast managed care. He doesn't deny that he's worried about his financial situation. But he's determined to stay the course, regardless. "To do otherwise would be soul-searing," he declares. "And I've seen this happen to some of my colleagues—they've sold their souls to the devil, and they haven't been happy doing it."

"I feel good at the end of the day. I feel I've done good work. The numbers are troublesome, but I'm usually thinking about what I've done or haven't done for patients." ■

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"Must you always have the upper hand, Ferguson?"

**Testimony delivered before the
White House Commission on Complimentary and
Alternative Medicine Policy Town Hall Meeting**

Friday March 16, 2001

**Presenter: Okokon O. Udo
Executive Director
The Center for Cross-Cultural Health**

Culture:

For the purpose of this presentation, I will define culture as “our learned world view that directs our thoughts and behaviors”. Thus defined, it goes beyond the traditional categories of ethnicity and race.

Holism:

The central belief in the following example of healing practice is that of holism. Quinn (1985) defines wholeness as an “integration, harmony and balance of mind-body-spirit in interaction with the totality of one’s environment”. A healer therefore, is the skilled practitioner who assists an individual in returning to a state of wholeness. Most of the world’s healing systems are holistic in beliefs and practices.

In Nigeria, among the Yoruba, a traditional healing ceremony takes place in a special center adjacent to the healer’s own house and may last for days or weeks. When the healer deems the patient fit to return to normal society, an elaborate discharge ceremony is performed. The rituals are done at a river in a deserted place. The patient first takes off her old clothes, and puts on a new white dress. Next her head is shaved and small cuts made in her scalp. The healer, her assistant, and the patient wade into the stream waist deep. The healer then takes one of three doves to be used in the ceremony and uses it as a kind of sponge, wetting it and rubbing it over the patient’s body, drawing out her illness, transferring it to the dove. This dove is then drowned and its body thrown downstream, along with the patient’s disease, which it has absorbed. The second dove is then killed and its blood smeared over the patient’s head and upper body. The vitality and calmness of the dove is thus transferred to the patient. The patient is washed and her bloodstained dress thrown downstream with the body of the second dove. Back on shore the patient is rubbed with medicines, and another dove is killed and its blood splashed over her body and then washed off. The patient then stands on the body of the dove, and an incantation is invoked. The body of the last dove is then thrown downstream with the declaration that the dead bird carries the patient’s sickness with it and that, just as water never flows upstream, so the patient’s sickness will never return” (Kinsley, 1996)

In the United States, a nurse trained in the use of Therapeutic Touch, enters a state of “relaxed concentration”. He then moves his hand slowly up and down a patient’s body (but does not touch it), searching for places where the “energy field” is blocked. After which the nurse performs movements to release the blockage, and balance the energy field. The energy field is thought to be part of the spirit, and the blockage of the energy is believed to be a cause of illness.

“In the American Southwest, a traditional Mexican-American healer holds an egg in her hand and moves it all over the patient’s body, especially the place where the disease seems to be localized. This process is to extract the sickness from the patient and transfer it into the egg. While “sweeping” the patient with the egg, the healer appeals to God, the saints, and other spirits to heal the patient. After the sweeping ritual the egg is burned, thus destroying the disease” (Kinsley, 1996)

Spirituality and Health

In most of the world's cultures, spirituality is a central component in health, sickness, and healing. Spirituality has been defined as "that which allows a person to experience transcendent meaning in life. This is often expressed as a relationship with God, or a particular religion, but it can also be about nature, art, music, family, or community – whatever beliefs and values give a person a sense of meaning, and purpose in life" (Puchalski, 2000).

Healing is a central concern for most religions, especially serious illness, raises basic questions about the meaning of life and the place of human beings in the cosmos; healing is often directly related to addressing these concerns" (Kinsley, 1996). Puchalski (2000) writes, "patients learn to cope with and understand their suffering through their spiritual beliefs, or the spiritual dimensions of their lives. Spiritual questions that come up for patients include: what gives my life meaning? Why is this thing happening to me? How will I survive this thing happening to me? What will happen to me when life ends?"

Traditional Healing:

An underlying assumption of many of the world's cultures is that the whole world is alive and interconnected. All of nature, including plants, rocks, and water, as well as animals and human beings have consciousness, will, divine power, and a soul. Human life involves the harmonious interaction of an individual's soul with the souls of countless others, both human and nonhuman. Daily life is understood to take place within a web of human and nonhuman relationships (Kinsley, 1996). Sickness results from an imbalance in one of these relationships.

The three important relationships in many cultures are:

- ◆ **Deities** – in many cultures there are one or more gods that are assumed to exist and to take interest in human affairs. Among many groups of people, some of which are represented in this country, it is affirmed that a god instituted human beings and laid down certain rules to guide human life and interaction with each other and the divine. Violations of these rules result in sickness or death. The god or gods can also heal illness with the use of prayer and rituals.
- ◆ **Ancestors and ghosts** – in some cultures the dead are believed to be very much concerned about the living, especially their descendants. Illness may be the result of not showing the proper respect toward one's ancestors through ceremonies and ritual. Among some groups of people, ghosts and demons are believed to be the cause of disease. These are often unhappy spirits of the dead, who envy the living. One can attract the attention of a demon due to "improper" behavior, or by the breaking of an important social rule. E.g. adultery or defecating in the community river.

- ◆ **Other human beings** – inconsiderate behavior towards other human beings also may precipitate a series of events that lead to illness. In some cultures illness is the result of envy or jealousy of an individual by another. There are human beings who have mastered techniques (rituals and charms) that enable them to harm and even kill their enemies.”

- (Kinsley, 1996)

Why am I talking about all these?

- ◆ Because our immediate and broader community is changing in every imaginable way. We are attracting people who are different from in race, ethnicity, sexual orientation, class, gender, socio-economics, religious/ spiritual beliefs etc.
- ◆ As a community, we therefore have a collective responsibility of making our guest feel welcome. It is the only proper way for treating a guest whose intention is to do no harm.
- ◆ It is not "us or them"; it is about all of us together.

Conclusion:

In a rather related way, Deborah Prothow-Stith, MD says something very profound. It is a timely reminder. “One way or the other, the children among us are going to get our time, and our attention, and our money, and our resources, and it is through public policy that we determine when”. Applied to the cultural-based healing traditions standpoint, “one way or the other, the diverse cultures among us are going to get our time, and our attention, and our money, and our resources, and it is through public policy that we determine when. I believe what we do not proactively anticipate and plan for, will someday overtake and cripple us.

Building Roads
an Oral Statement to
the White House Commission on
Complementary and Alternative Medicine

March 16, 2001 – Minneapolis, Minnesota

Michele Denize Strachan, MD

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,

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 access 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 also 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 licensed physician, nurse practitioner, nurse midwife, or physician 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.

Powderhorn/Phillips Cultural Wellness Center

Cultural Health Practices

Cultural health practices exist within a knowledge system founded on a set of underlying assumptions. In this system, life is not limited to the aliveness of the physical body. The person is understood as a reflection and an extension of his/her place within the universe, the environment, the community and the family. The person is the place where powerful forces of relationships intersect. These relationships include interactions with family, elders, children, community, as well as with work, nature and the invisible elements.

Cultural health practices are based on a relational way of thinking where disease which expresses itself at the physical level has parallel manifestations in the emotional, mental and spiritual. Healing at any level would then also have parallel manifestations at the other levels. More than the causation of disease, cultural health practices focus on "the message" inherent in a particular disorder for other aspects of a person's life and vice versa. The aim of cultural health practices is the restoration of harmony; the process is anchored in relationships. Many tools and techniques — herbs, manipulating the environment, symbols, stories, rituals, chanting, bodywork and manipulation — are used to support the fundamental process of restoring harmony.

Cultural health practices are a distinct knowledge system which cannot be understood within the framework of modern science. Science's theory of causation and methods of obtaining proof are limited to the physical and empirical levels. The existing health system's separation of mental health practitioner from physical health practitioner from spiritual health practitioner does not apply in cultural health practices. "Modern" medicine and science often shun and ridicule indigenous medicine and have successfully driven it underground. Indigenous practices and practitioners abound, however. We know of them through conversations with community members, through the work of cultural and medical anthropologists, and through the efforts of the popular press. They include the practice of the Hmong shaman, the African shaman or herbalist, the traditional Chinese healer or herbalist, the Ojibwe, Lakota or Potawatoni medicine men/women, the traditional midwife in many cultures, and the Latino curandero/a. Utilization rates, however, are inaccurate, since both the practitioners and the users in most cases exist "underground."

Within the emerging concepts of psychoneuroimmunology, cultural health practices have a vital function to fulfill especially among people of indigenous cultures. They can extend the scope of the medical practitioner by presenting the concepts of psychoneuroimmunology with a process, with a language, and within a mode of thought and knowing that is integral to the person seeking help. Healthy lifestyle decisions, and the patient's taking an active role in his/her own process toward wellness are areas where the conventional medical

system is failing, especially with people of non-European heritage. A space where cultural health practices move above ground and play an active and collaborative role with medical science will insure the optimal well-being of all as the nation moves to Healthy People 2000.

The Powderhorn Phillips Cultural Wellness and Health Education Center in Minneapolis, Minnesota is one place committed to creating, building and nurturing that space where cultural health practices and medical science interface. The Cultural Wellness Center teaches, advocates and facilitates discoveries and connections with one's community. The Cultural Wellness Center evolved from Healthy Powderhorn, a program funded by the Allina Foundation. Healthy Powderhorn hosted over 1,000 meetings within the communities in South Minneapolis and developed the "people's theory" of what contributes to sickness and health.

The focused sessions with people from many different age groups within many cultures led to an agreed upon position and understanding that illness and disease come upon a person as a result of individualism, isolation, and a loss of belonging to culture and community. The people involved in the development of the Center affirmed that wellness and good health are attained by pursuing spirituality, healthy relationships with family, elders, children and accessing one's own community and heritage, including indigenous healers

The Center offers classes which focus on three areas: 1) Reconnection to Heritage, 2) Educated Lifestyle Practice, which investigates our relationships to nutrition and movement and 3) Restoring and Maintaining Harmony, which builds skills and offers support in healthy community building and personal bonding to kinship networks.

Cultural wellness emphasizes the sacred knowledge people have brought with them from across the globe. The people and their cultural knowledge, wisdom, customs, beliefs and norms now co-exist within a contemporary context. The Cultural Wellness Center creates a space to bring together these unique cultural ways for sharing community and health within an individualistic and fast-paced society. Cultural healing affirms each culture as knowledgeable, resourceful, effective, important and valuable on its own. Members of each culture are enlivened and empowered by the dialogue they share within their community and with other cultures.

Cultural healing practices affirm that rituals, stories and experience-based testimonies are a legitimate way of expressing knowledge. Sharing meaningful symbols and stories creates a harmony that contributes to personal and community wellness.

My name is Thupten Dadak. Thank you for giving me the opportunity to speak before the panel today. I will be speaking about traditional Tibetan medicine.

Briefly, I will outline the historical background up to the present. Tibetan medicine dates back to before the seventh century and has its roots in pre-Buddhist Tibet. It developed in Tibet with strong Buddhist influence and has a long scholarly and scientific tradition which was nurtured by the unique Tibetan monastic education system. Tibetan doctors typically studied for thirty years and were recognized in their communities as respected scholars and venerable wisdom masters, similar to the learned lamas of the great monasteries. The community revered doctors for their deep understanding of the life forces and how to achieve a healthy, happy, balanced life. Tibetan doctors were depended upon to assist with all of life's changes, including the achievement of a peaceful, compassionate death.

IN 1959, the Chinese invaded Tibet and began systematically destroying Tibetan culture, especially its intellectual forms such as philosophy and medicine. Six thousand monasteries were destroyed. Ancient texts and practice materials were burned and thousands of Tibetans were jailed or killed. *(The current Director of the Tibetan Medical Institute was jailed for more than twenty years, for example.)* The Dalai Lama led many Tibetan people into exile in India as a means of survival.

Tibetan medicine has survived into the 21st century due to the Dalai Lama's wise priorities: he established the Tibetan Medical Institute as part of his Tibetan Government in Exile in India. He assembled the surviving elder physicians with their remaining texts and resources, and wisely ensured the transmission of the master physicians' knowledge to a new generation of young doctors educated in exile. The medical education program was pared from 30 years to 7 years to insure there would be new doctors with core skills to work with the elder master doctors.

The physicians of the Tibetan Medical Institute have actively participated in East/West dialogue with the most prestigious medical institutions all over the world. *In 1998, 120 scientists & researchers attended the International Congress on Tibetan Medicine in Washington, D.C. The University of Minnesota will hold a Tibetan Medical Conference here in May. Also, the FDA recently approved Tibetan medicines for breast cancer research trials at the University of San Francisco. There is increasing interest in Tibetan medicine's unique achievements in pulse diagnosis, medicine formulation, and its compassionate ethical traditions.*

The great potential in the integration of Western and Tibetan medicine is being recognized.

It is important that public institutions and the U.S. government continue to support the research in appropriate academic settings removed from commercial pressures. The future contributions of Tibetan medicine in the treatment of cancer, AIDS, heart disease, etc. is not yet known but the Tibetan texts speak of these diseases and their treatments. The translation and scientific examination of texts takes time and great care. Every year, the Tibetan Medical Institute is approached by large pharmaceutical companies with offers to purchase formulas and medicine patents, but the Institute has declined all offers due to its responsibility to preserve the integrity of Tibetan medical traditions.

I hope that the wisdom of the ancient texts will be studied in the great western universities and hospitals.

Please support the funding of scholarly research of Tibetan medicine so that its science and compassionate ethical traditions will enrich the wider world.

Thank you.

Subject: WHC Testimony
Time: March 16, 2001
Place: Hubert Humphrey Institute,
University of Minnesota

My name is Chunyi Lin, the founder of Spring Forest Qigong technique, and the Director of Qigong Program of Anoka-Ramsey Community College. Before I came to work at Anoka-Ramsey Community College, I was a college professor and Qigong master teaching English, Chinese writing, Qigong, Taichi and healing in China. Now I have been teaching Qigong at Anoka-Ramsey Community College for six years since 1995.

Through my observation, the health system in the United States has only been focusing on integration in the hospital and clinic setting. It seems to me that only hospitals and clinics can provide and promise health to people. This setting does not match with the philosophy of a country with great cultural diversities, and does not match with the spirit of health and healing. Hospital/clinic setting is a great tool to help people get well. But the most important thing is to have people stay healthy. In order to achieve this, it is very important to allow people in their everyday life to take good care of themselves with their health. So besides hospital/clinic setting system, we need to develop a self-healing system, by giving respect to all cultures and allowing all forms of healing from different cultures to join in the big healing family. Qigong is an ideal technique to serve this purpose.

Chinese people have been practicing Qigong for over five thousand years. Now in many hospitals in China, we offer western medicine, traditional Chinese medicine, and Qigong to patients. In China, almost every family knows some techniques of self healing, such as herbal medicine, tuina, guasha, massage, heat healing, cupping, and Qigong. Many health problems are taken care of before they grow into bigger problems. People through practicing Qigong, prevent illness from happening, and when they are sick, they get healed faster and more completely physically and spiritually without side effects, anxiety and pain.

Qigong is an exercise. It combines the body, the mind and the spirit together in the healing. As a Qigong master with years of experience in Qigong practice, my vision in this country with my development of Spring Forest Qigong is to have A HEALER IN A FAMILY AND A WORLD WITHOUT PAIN. I teach people how to understand this ancient wisdom in taking care of the body through self-healing and it works! Here I want to share the growth of the enrollment information of the Qigong program at Anoka-Ramsey Community college with you, so that you will see the enthusiasm of people with Qigong, and the importance of Qigong in these people's life. People come to the class not for the curiosity of the Chinese wisdom, but for the knowledge of health and the power of self-healing.

The academic year 1995-96, 100 students. 1996-97, 113 students. 1997-98, 1250 students. 1998-99, 1525 students. 1999-00, 1925 students. 2000-01, 2400 students. These numbers do not include the workshops and seminars I did outside the college. More and more people in the country now realize the power of Qigong.

In the past few years, Spring Forest Qigong has already helped thousands of people healed with their pains and aches, and has made a great contribution to both American and Asian communities in Minnesota and the country. I have been frequently invited to speak in the health care system nationally and to participate in medical research with different kinds of diseases in universities and hospitals. I am willing to do any kind of medical research with Qigong in this country to help people scientifically better understand the healing power of this ancient art of Chinese healing.

Here are my suggestions:

- A) I recommend that as all cultures be respected in this country, all forms of healing be acknowledged and allowed in this country too – no suppression.
- B) I recommend that all forms of healing be encouraged and free and that individuals can utilize for their own self-healing, so that people be allowed to take responsibility of their own health and self-healing.
- C) I recommend that we have a positive cultural climate and information with other cultures and reap the benefits of wisdom from all cultures.

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001. testimony	Chunyi Lin (partial) (1 page)	03/16/2001	b(6)

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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

- D) I recommend that, because of the safety, no side effect, the simplicity and healing power of Qigong, Qigong be a part of educational curriculum for healthcare practitioners.
- E) I recommend that researchers utilize Qigong masters in their research projects and to teach medical doctors about Qigong.
- F) I recommend that the government not put legal barriers up regarding Qigong so all persons can always teach and practice Qigong.

Chunyi Lin

(b)(6)

Chanhassen, MN 55317

(b)(6)

Linsfqigong@msn.com

My Dakota name is Zuzuhichiday Hinyukan Boy.
 My Toltec name is Quetzlequail Boy.
 My Mayan name is Kulkukan Boy.
 It means Feathered Serpeant Boy.

I was asked to speak on solutions for problems which indigenous people may have regarding laws and regulations which would affect their healing practices and, in turn effect their way of life.

How do you speak about solutions to a problem when we indigenous people believe there is no problem?

When I speak of indigenous people I speak not only of indigenous people to the America's, but to all indigenous people of this great mother which we call earth, be they of the black, red, yellow, brown or white race.

I speak of indigenous people who were free at one time to practice the healing arts of herbs, plants, sweat lodges, danza's etc.

I speak of a time when this practice was passed on by word of mouth, family to family, mother to daughter.

We still practice and teach this way. After the conquest of indigenous people on earth, we were forced to go underground, to hide from the ones who would want to destroy our way of life.

While they inflicted great harm to us, we were never defeated.

The gifts of healing we have received from the creator is a gift that is to be used to help the people.

The people that we serve are amongst the people who do not have money or health insurance, do not speak the language, do not trust the medical doctors or have come to us because the medical field has failed to help them.

We indigenous people see no problem with the use of alternative medicine to help people with their various illnesses.

The problem that I see is a system that attempts to impose their laws and regulations on us to attempt to control and manipulate healers and the practice of alternative medicine while the system may pass their legal laws and regulations, if these laws interfered with my ability to help the people, I would refuse to abide by them.

SOLUTION

No laws or regulations in the attempt to control and manipulate the use of alternative medicine.

American Association of Immigrants From the Former USSR



Illinois Branch

1132W Lunt Ave. Suite #9D, Chicago, IL 60626

Tel: (773)338-5055 Fax: (773)338-5120

Presentation at the Meeting of
White House Commission
on Complementary and Alternative Medicine
March 15, 2001, Minnesota, MN

Mr. Chairman and members of the Commission,
my name is Sabina Pello and I am the President of the Illinois Chapter of the American Association of Immigrants from the former USSR (AAFUSSR).

To-day I am authorize to represent the Brances our organization from many states of USA.

I appreciate the opportunity to address this distinguished panel today.

I would also like to thank the Coalition for Natural Health for bringing this important meeting to my attention.

Many of you might be familiar with the Coalition through their instrumental role in helping to achieve the passage of the Complementary and Alternative Health Freedom of Access Act here in Minnesota.

But there remains much work to be done.

It is, indeed, unfortunate that in a country founded upon the precepts of "unalienable rights," many legal residents do not have the freedom to make decisions regarding what should be their most basic personal responsibility - their health.

This situation is particularly critical for thousands of legal immigrants, mostly elderly, from East Europe, Asia. and South America who are systematically denied access to the natural health modalities and natural supplements, which were fundamental to their healthcare in their native countries.

These traditional practices were passed down from their ancestors, in many cases, for thousands of years and they worked well to ensure good health and to promote natural healing.

Now. unfortunately, most of these people are unable to continue their healthy traditions.

A majority of legal immigrants over 65 years old are covered by Medicare - but Medicare does not cover these traditional practices.

Many of these legal immigrants try to find their traditional remedies on the shelves natural food stores yet they fail to identify them because they are unfamiliar with their American counterparts.

In many cases they are attempting this course of action because of dissatisfaction with medicine prescribed to them by doctors.

What a travesty that the traditional, natural and more cost effective option is not available to

them.

My organization attempts to intervene on their behalf by providing our elderly with sessions of Healthy Life Style, Nutritional ABCs and some common sense natural preventative measures, however, there are still many among them who still have no access to the traditional products that they desperately need.

These people cannot perceive why a democratic and humane society is denying them their right to be healthy and happy, or why costly allopathic care is being forced upon them when they desire access to centuries-proven and less expensive natural methods.

We, on behalf of our constituents, are addressing these issues with the proper authorities for their consideration, with the hope that our society can prove its appreciation of high moral values by advancing the cause of human health and well-being.

We believe that every person has the right to choose his or her own form of healthcare in a free and democratic society. Healthcare is a personal right, just as the freedom of speech and worship, and it is the constitutional right of the American population, and particularly of such a vulnerable elderly as our immigrants.

Thank you for your time and attention.

Sabina Pello
President, AAFUSSR, Illinois

AAJFUSSR

Georgia Chapter

3601 Piedmont Rd, 201, Atlanta, Ga, 30305

Phone, Fax (404) 262-1912

The right for traditional Healthcare

We consider that legal immigrants, as well as the population of USA have their right of choice in Healthcare.

On behalf of our community we are addressing our concern regarding the accessibility to the traditional Healthcare.

National Vice President of AAJFUSSR

YAMA Bari / Bari

Execute Director of Georgia Chapter

Maara Mabeceviel / Maara

NEW JERSEY ASSOCIATION OF JEWS FROM FORMER SOVIET UNION

543 Sagamore Ave., Teaneck, NJ 07666; T.(201)836-7960; FAX (201)692-0215; e-mail: rashin@usexpress.net

WE SUPPORT THE RIGHT FOR THE TRADITIONAL HEALTH CARE.

Millions of Americans, who immigrated to the US, are used to and trust the traditional health care, effectively practiced for thousands of years. While we support scientific verification of the efficiency of some of the methods and establishment of licensing procedures for their practitioners, we believe that everybody should have access to such established methods, and that they should be universally covered by the health insurance.

We join others in asking the White House Commission (WHCCAMP) to affirm such a right, and trust Dr. Sabina Pello to convey our opinion to the Commission at its meeting in Minneapolis on 3/16/01.

3/14/01 President of NJAJFSU, Alex Rashin, PhD

Members of the Board: Vitaly Raevsky, PhD

Miron Reidel, Journalist

Alexander Rashin
Vitaly Raevsky
Miron Reidel

WHITE HOUSE COMMISSION ON COMPLEMENTARY
AND ALTERNATIVE MEDICINE POLICY

March 16, 2001

Written Statement of
Tom Hiendlmayr, Director
Health Occupations Program
Minnesota Department of Health

Good afternoon. My colleagues and I will be establishing in the Minnesota Department of Health, the Office of Unlicensed Complementary and Alternative Health Care Practice that was enacted by the 2000 Minnesota Legislature and is effective July 1, 2001.

We have had several questions about the start-up and operation of the Office, and I would like to tell you how we are answering them:

- What concerns, difficulties or challenges are we anticipating in establishing and operating the Office of Unlicensed Complementary and Alternative Health Care Practice?

As you may know, the regulatory scheme for the Office is based on a model for unlicensed mental health practitioners that has been conducted in MDH for the last 10 years. Susan Winkelmann has a decade of experience managing that program, and, excepting the subject matter, the new activity is nearly identical to regulation that we have done for some time. So, while we are excited and looking forward to July 1st, we are not expecting any problems.

- How are you going to notify people about the new law? How will you know who is supposed to know about and comply with the new law?

We intend to use public service announcements and news releases to the many media resources in the community. Many providers advertise in local publications and others have called MDH so that we are building a mailing list of interested persons and organizations. There is, however, the idea that if practitioners do not have to file or register with MDH, we can't regulate them. In practice, consumers and other practitioners tell us what we need to know, just as in occupational licensing schemes.

- How is MDH going to enforce the new law if there are no standards for practice? How is the law going to keep people from doing whatever they want to do?

There are 24 professional and ethical standards in the law, items "a)" to "x)." Our experience in regulating five health-related occupations that have competency standards is that almost all the time, consumers are harmed by violations of one of the standards listed in the law. We do not now see any need for changes in the law, but if we do, we will report to the Legislature in two years about that.

WHITE HOUSE COMMISSION
ON
COMPLEMENTARY AND ALTERNATIVE MEDICINE

Michael J. Myers, J.D.
Chair, Health Services Administration
School of Business/School of Law
University of South Dakota
[Former Mayo-St. Marys Hospital CEO]

STATEMENT

My name is Michael Myers. I teach at the University of South Dakota School of Business and School of Law. I am a former CEO of Mayo-St. Marys Hospital, Rochester, and frequently lobbied Congress on behalf of the AHA.. I have hosted a talk radio show giving a collective voice to physicians and alternative practitioners. I engaged in a failed attempt to establish integrative clinics with "clinical parity." I have been on both sides of this issue.

I laud the Commission's charge to "ensure that US public policy maximizes the benefits of complementary and alternative medicine." When you discuss this matter with President Bush, may I suggest that you recommend the following:

1. Read "Medical Nemesis: The Expropriation of Health," (1976) by social critic Ivan Illich, wherein he asserts that "The medical establishment has become a major threat to health," and describes medicine as an epidemic.
2. Review the Rand Corporation research led by Dr. John Wennberg of Dartmouth that looked into "The Black Box of Medicine," and concluded that choice of care may be influenced more by finances than by medical science.
3. Read "Rats, Drugs and Assumptions," by Majid Ali, M.D., describing the pharmaceutical industry's influence on medical education and why university researchers overstate the benefits but understate the risks of drugs.
4. Fund three to four "Demonstration Clinics of Integrative Health Care " to conduct research into the cost and effectiveness of care delivered by an integrated staff of conventional and complementary practitioners. (Seven years ago I, along with a surgeon and naturopath, attempted to establish three clinics of integrative medicine in South Dakota, Iowa and Nebraska, believing the market was ready for a new type of medicine.) It was not.

5. Fund research for three to four “Employer Defined Contribution Plans” with a medical savings account feature that rewards employees for good health and seeking cost-effective care. (E.g., \$2,000 annual fund with keep-what-you-don’t-spend roll-over feature).
6. Support freedom-of-access legislation that discerns between regulation that is essential for “public welfare and safety” and laws that are for the “economic welfare and safety” of sellers who hold licenses and certification.
7. Use the Minnesota Complementary and Alternative Health Care Freedom of Access Law as a model that removes natural health practitioners from under the jurisdiction of state medical boards and grants to individual citizens the personal freedom to choose.
8. Also, suggest that President Bush once again read Milton and Rose Friedman’s “Freedom to Choose.”

#

Policy Issues for the Regulation of Occupations

Morris M. Kleiner
Humphrey Institute of Public Affairs
University of Minnesota

The study of occupational licensing has a long history in economics dating to the founding of economics by Adam Smith in the 18th century. The basic findings are that there are few benefits of licensing relative to for example, the certification of an occupation. Studies in the economics literature summarized by the Simon Rottenberg in a book that he edited entitled Occupational Licensure and Regulation found some important impacts of occupational licensing which I will summarize in the following three paragraphs.

First, Rottenberg found that occupational licensing is primarily promoted by practitioners of the occupation rather than by consumers of its services. Licensing is said to primarily serve the interests of practitioners rather than the interests of consumers. Second the public interest defenses for occupational licensing is of questionable merit. Lobbying and percent of the occupational association's budget allocated to political activity often determines whether an occupation gets licensed. Third, whether licensing results in improvement in the quality of service offered is debatable. It is not certain that quality of service is improved if a license is required for the performance of an occupation, and often low income persons suffer the most because they cannot obtain the service of a higher priced licensed service.

Once an occupation is licensed there are often restrictions of entry for others. The enforcement of the monopoly right of licensed persons to practice a licensed occupation is frequently undertaken by private professional associations of licensed practitioners who use agencies of the state as instruments of enforcement. Examining boards in licensed occupations are frequently comprised of licensed persons in the relevant occupation and only infrequently include representatives of consumers of the services of the occupation. Examining boards are able to control the rate of entry into a licensed occupation by manipulating the "pass rate" of those taking the licensing examination. The pass rate will be sometimes high or low, depending on the state of earnings and employment of those already in the licensed occupation. The manipulation of the pass rate is evidence that examining boards administer licensing legislation primarily to protect incumbent practitioners in the licensed occupation.

When practitioners in an occupation promote the licensing of that occupation, they frequently permit incumbent practitioners to continue to practice in the occupation without being required to pass a competence examination. Incumbents who are "grand parented in" will earn a monopoly return in the practice of the occupation. Practitioners in a licensed occupation are given an advantage if the standards and costs of entry are made higher than they were when current practitioners entered the relevant occupation. Practitioners have an incentive to promote continuously higher standards and costs of entry into licensed occupations. Finally, the licensing of an occupation reduces the number who practice that occupation. Those who are excluded make their way into other occupations: they are less productive in those second-best occupations than they would be in the licensed occupation from which they are excluded.



Minnesota Board of Medical Practice

Presentation on Complementary and Alternative Medicine to the White House Commission on Complementary and Alternative Medicine Policy

March 16, 2001

**WHITE HOUSE COMMISSION ON
COMPLEMENTARY AND ALTERNATIVE
MEDICINE POLICY TOWN HALL MEETING**

MARCH 16, 2001

MINNESOTA BOARD OF MEDICAL PRACTICE

**ROBERT A. LEACH, J.D
EXECUTIVE DIRECTOR**

The Minnesota Board of Medical Practice is the state agency charged with the credentialling and regulation of physicians and five other health care professions; physician assistants, respiratory care practitioners, athletic trainers, acupuncturists and traditional midwives.

The Board of Medical Practice has a long history of cooperation with non-traditional health care professions in ongoing efforts to incorporate alternative and complementary treatments into the health care system. In addition to undertaking the responsibility to regulate the practices of acupuncture and traditional midwifery, the board has recently participated in unsuccessful legislative efforts to bring the credentialling of Naturopaths to Minnesota.

Because the board's statutory jurisdiction is regulation through the enforcement of the Minnesota Medical Practice Act, it has approached complementary and alternative health care practices from two separate perspectives; credentialling providers of those services, and ensuring that practitioners of those modalities do not violate the Medical Practice Act's prohibition of practicing medicine without a license.

Under the Medical Practice Act, the board's statutory responsibility is public protection. The Board feels strongly that the credentialling of alternative and complementary practitioners through state licensure or registration is the safest and most effective way of assuring that consumers of many of these services are protected from unqualified, unprofessional and fraudulent practitioners.

It is only through credentialling by a state agency charged with public protection that consumers can be assured that the health professional they are seeing has met certain minimal educational and training qualifications which help to ensure that they are safe to practice. Credentialling also provides a regulatory authority, which can be utilized to ensure that a practitioner continues to practice safely and is required to pursue continuing education on up-to-date methodologies, technologies, and safety issues.

The board, in its enforcement of the Medical Practice Act is concerned with the practice of alternative and complementary providers which may be in violation of the Minnesota Medical Practice Act as currently written. Holding oneself out as a naturopathic physician for instance is a violation of the law since the title "physician" is limited to those licensed individuals holding MD or DO degrees. The theory behind this enforcement is that utilization of the title of physician can be misleading to the public in terms of the individuals actual credentials.

In addition, under the Medical Practice Act, only physicians are legally authorized to diagnose and treat medical conditions. The Board would urge practitioners of alternative and complementary care to become familiar with the restrictions set forth in the Medical Practice Act relating to the unlicensed practice of medicine.

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16 March, 2001

Distinguished Members of the Commission, Regulation Panel members, and esteemed Colleagues,

I am Rebecca Frost, the Liaison for Regulatory Affairs for the International Somatic Movement Education & Therapy Association also known as ISMETA. I also serve on the Joint Government Relations Committee of the Federation of Therapeutic Massage, Bodywork and Somatic Practice Organizations. For your convenience, a page is included in your packet which provides information on these organizations, a list of which somatic practices are represented (in excess of 15 different approaches), and my additional credentials. I am also in private practice as a registered movement therapist and educator.

I am aware that you are ready to hear recommendations for action which will resolve longstanding issues and move us forward toward greater access and responsibility. I will get to some specific recommendations. **For a second, I'd like to engage your attention in the large and long view of the visionary nature of the work we are all engaged in.** How we define anything at this point in time may be subject for revision in an emerging frame of consciousness. As we enter into regulatory questions, we are participating in creating the shape and impact our fields will have on future generations.

Somatic practices occupy the cutting edge of the complementary field, helping to shape and herald the consciousness that will emerge in the subsequent generation of alternatives. Somatic practices can involve elements of the allopathic treatment paradigm, as well as employ the theoretical framework which underlies education. Advocacy to separate therapy and education arises partially from legitimate differences in practice and philosophy. But also in response to the inaccurate classifications practitioners have endured. These result in the subsequent fear of being unduly regulated, thereby increasing expense for all. Or, for lack of legitimacy, being excluded from the option of third party payment, potentially limiting access for some. Certainly, there are diverse positions within the field. I am attempting to provide some context and perspective.

Since I've had the benefit of reading transcripts of previous testimonies, I know one question you've posed, Dr. Gordon, pertains to the division between 'therapy' and 'education', and whether or not we in the somatic practices see any way our profession might appropriately fit into an expanded notion of what health care might encompass. As you know, time and again, we've made the argument that an educational modality in which the recipient is consciously engaged and gaining knowledge and skill in order to make new choices and behaviors, is a very different paradigm than one which is primarily treatment based, in which the patient may be passive, with little active role in how the treatment is administered. We have used this distinction to maintain the inappropriateness of governmental regulation on somatic education.

Can somatic therapists and teachers cite any conditions under which we might be included in health care? I submit the following six recommendations: 1) Legitimize the paradigm differences between systems. Recognize that the various practices do not all lend themselves to the same regulation structure. 2) Allow regulatory standards to be developed by practitioners from specific fields; standards which are true to the model they represent. 3) Consider developing federal guidelines for such methods that support us to voluntarily and responsibly self-regulate. 4) Make use of the expertise of the JGRC, the committee I referred to in my introduction which responds to arising needs in the regulation of somatic practices. 5) List the professions represented by ISMETA under Category II- Mind-Body Interventions of the NCCAM classification, not Category V-Manipulative and Body-based Systems- Massage and BodyWork. Note the fact that the NCCAMP classification of CAM practices was developed for research purposes. However, it is being used by other governmental agencies, such as the Dept. of Education as a model for their classifications of instructional programs (which in turn influences the O*NET categories). Redirect your attention to the concerns about classification of CAM practices raised in Martha Eddy's testimony, panel 17, NYC. Her follow-up letter of February 23 includes elaboration on our desired ways of being classified; it will instruct you and illuminate this point. 6) **Develop and fund research models appropriate to the somatic field. Increase the variety of research models accepted by NCCAM to include qualitative studies, combined quantitative and qualitative approaches, and single subject analyses as well as multivariate analyses.**

Thank-you for your attention.

3 minute WHC

TO: THE WHITE HOUSE COMMISSION
 FROM: MARILLYN BEYER, B.S.N (1947), M.A. (1977)
 PRESIDENT: MINNESOTA NATURAL HEALTH COALITION
 INSTRUCTOR: ANOKA/RAMSEY COMMUNITY COLLEGE
 ENERGY HEALING COURSE

As a result of a phone call on 3/13/1, I have limited this testimony to three minutes and have focused on recommendations relevant to licensure.

Licensure has politicized the delivery of health care. It has created a medical monopoly that has dominated the delivery system. This fact has often been ignored.

Primarily as a result of licensure the consumer has been locked into one single, very expensive model of mandated coverage either through Medicare or employer packages. This is forcing us to use our most highly educated, most hi tech, most high risk and most expensive care for our covered benefits. We are paying for this whether it is the care that we would opt for or not.

THIS IS VERY INEFFICIENT AND COSTLY!!!

My RECOMMENDATIONS to resolve this problem are:

(I suppose that this originally would need to be done for Medicare coverage, since I assume this is the only benefit package you can impact at the national level. (We encourage any insurance people here also to listen).

1. KEEP ALL NATURAL HEALTH PROVIDERS FREE FROM ARBITRARY EDUCATIONAL STANDARDS. (NO LICENSURE OR REGULATION)
2. FUND NATURAL HEALTH EDUCATION AS IT NOW IS AND HAS BEEN FOR GENERATIONS. - *non institutionalized*
3. DEVELOP A TASK FORCE TO REVIEW THE LITERATURE ON NATURAL THERAPIES. AUTHORIZE COVERED BENEFITS FOR THOSE WHICH HAVE SHOWN GOOD RESULTS. I have seen research done with Blue Cross/Blue Shield of Iowa showing extensive savings--- EVEN in the elderly.
4. DEVELOP POLICIES THAT ALLOW FOR ANECDOTAL AND TESTIMONIAL APPROVAL OF THERAPIES AND THERAPISTS. This means that no therapy will

be arbitrarily denied because there is no research on it. We all know the difficulty of getting research funding where there is no expectation of large profits. We can provide you with some good data on outcomes.

5. **TWO CHOICES OF COVERAGE MUST BE MADE AVAILABLE TO ALL INDIVIDUALS. (ALLOPATHIC AND NATURAL)** The natural plan would cover subacute and chronic diseases. A major medical could also be offered . The individual would select the type of coverage that has produced the best outcomes for them and that they have the most faith in. As a nurse educator, I gave a basic principle to my students. "The broader the range of options, the higher the probability that the desired outcome will be achieved."
6. **CONTINUING APPROVAL OF THERAPY WILL BE BASED ON OUTCOMES- meaning WHETHER OR NOT THE PATIENT'S STATUS HAS IMPROVED.** There no longer should be approval of endlessly unchanging treatment patterns that lead only to more of the same treatment without significant improvement and especially if further deterioration has occurred . A six month trial period might be offered. At that time – or at anytime -the client will have the option to switch to another form of coverage – to a new primary care provider IF they so desire.

(Any nursing student would have had a hard time graduating if she persisted in applying a nursing care plan that was ineffective. She would search for other options)

I must add that the Minnesota Natural Health Coalition has just this last May assured ourselves that the services that we want will be there when we want them. As an organization we have not asked, nor even considered the issue of coverage or reimbursement. But the charge for this testimony was to make recommendations relevant to the topic I was assigned. I see patterns of delivery of health care as being **VERY RELEVANT** to the issue of licensure.

So these recommendations are **MY DREAM!** However, I must say that I have heard these same words from many, many individuals.

THANK YOU FOR THE OPPORTUNITY TO PRESENT TO YOU TODAY. WE HOPE WE CAN DEVELOP A CONTINUING RELATIONSHIP WITH YOU.

PRIOR TESTIMONY--- FOR 5 MINUTE TIME LIMIT- PLEASE READ!

NEW DIRECTIVES ON 3/13/01 RESULTED IN CHANGED TESTIMONY

To: THE WHITE HOUSE COMMISSION

I am Marillyn Beyer, B.S. P.H.N., R.N. since 1947, an M.A. in 1977. I am also the President of the Minnesota Natural Health Coalition. But I come to you today as a consumer seeking to obtain the health care of my choice so that I can reduce my costs and obtain better outcomes through the use of more options.

There are many BARRIERS to this.

One is REGULATION

. Originally this panel had two people representing licensing boards and two from the consumer group which passed the Minnesota Model for Freedom of Access To Natural Health Care. That structure modeled the problem --- us against them. Licensing has politicized the delivery of health care.

This is not what the Natural Health Community desires. We believe in and try to implement healing and wholeness.

But licensing IS a model of kingdom building, castles with high walls and moats surrounding it. The kings within look out over the parapets and say, “ We rule here!! “ To those of you on the outside, we say, “ Our Governor can beat your governor and what’s more, our curriculum is better than your curriculum. We will make it illegal for you to do what you do. We do not care what you have studied, how you have studied or how many years you have studied! We don’t care if you have a list of a thousand clients that are perfectly satisfied and HAVE BEEN HELPED by what you do. We don’t care. We will destroy your rights to give this service”.

And the Community says “ WHAT?- We can’t get this service from the people we want to ? Our children and grandchildren cannot learn and do these things in ways that have been done for centuries! WE ARE BEING DENIED!!! WE ARE BEING ROBBED OF OUR RIGHT TO LEARN and SERVE IN OUR OWN WAY!!!!

So ? ---- Do we go to the people within the kingdom?

But when we are there, we are told. “ Sorry. I can’t give you this service. It is not covered in my license.”

We are shocked and say, “ But- you know about it and have the skill?!!”

Yes, but I can’t help you”

Shocked, we say, sadly, “Then refer us. We want and need this service”

The answer, “ I am sorry , don’t you understand, I can’t refer. It is not allowed.”

SO, here we are , frustrated, annoyed, and even angry! Now we must find someone else, another visit, more time, more hassle, another cost. WE ARE BEING ROBBED AND DENIED!

And we think as we leave, “well, maybe it’s all for the better. We know the people within the castle walls would charge a LOT more money.”

And then we think, “Good grief! The people within the castle are being held hostage by their own king!”

SO- LICENSURE CREATES A POWERFUL AND COSTLY BARRIER TO OUR OBTAINING CARE THAT WE WANT FROM WHOM WE WANT. WE WANT TO MAKE THESE CHOICES! WE DO NOT WANT LEGISLATION INTERFERING WITH THIS RIGHT.

The second BARRIER to our obtaining the care we want from whom we want is HEALTH CARE PACKAGES.

Primarily as a result of licensure, WE ARE LOCKED INTO ONE SINGLE MODEL OF MANDATED COVERAGE EITHER THROUGH MEDICARE OR EMPLOYER PACKAGES.

The cost of these packages is escalating and not producing benefits proportional to the increases in costs. There are three problems as I see it here.

FIRST: We are using our most highly educated, most hi tech, most high risk and most expensive provider as a doorkeeper to the whole health care system. VERY INEFFICIENT!! There is, in effect, a medical monopoly!

SECONDLY: The focus is treating the symptom – the end stage of a very long and complicated process. That’s a little like trying to shut the barn door after the horse has been stolen.

We need to focus more of our attention on those approaches that seek to make changes at the level of cause- at the incipient level of imbalance, before a disease entity has ever appeared.

PREVENTION AND HEALTH PROMOTION IS MORE EFFICIENT --- LESS COSTLY!!!

THIRD: We need to relate coverage to outcomes. There should be an end to endlessly unchanging treatment plans that lead only to more of the same treatment without significant improvement or even continued deterioration and complications arising from treatment. People should have the option of changing plans and primary providers if they are not achieving the outcomes that they are seeking!

In conclusion:

WE URGE YOU TO RECOMMEND POLICIES THAT ENSURE OUR FREEDOM TO CHOSE WHOMEVER WE WISH FOR CAREGIVERS. WE DO NOT WANT LICENSURE FOR OUR NATURAL HEALTH PROVIDERS.

WE URGE YOU TO DEVELOP INNOVATIVE RECOMMENDATIONS THAT REQUIRE EXPANDING OPTIONS OF COVERAGE TO INCLUDE NATURAL HEALTH THERAPIES. WE PARTICULARLY WANT THIS IN THE AREA OF SUBACUTE AND CHRONIC ILLNESSES.

DO THIS AND WATCH THE SAVINGS!!!!!!!!!!!!!!!!!!!!!!.

To: The White House Commission on Complementary Medicine Policy
From: Diane Miller JD, Exec Dir, National Health Freedom Coalition
Date: March 16, 2001
Place: Minnesota Hubert Humphrey Institute

Dear Commissioners:

Thank you for coming to the heartland. We are honored to have you.

As you know, we have designed a new statute in Minnesota that protects individual rights to access unlicensed health care practitioners. I have an hour presentation prepared explaining the legal theory and reform philosophy of this new law and I hope you invite me to give you that presentation some day. For today I would like to ask you to review the law and remember that:

1. MN Stat. 146A protects consumer access to unlicensed health care practitioners by allowing unlicensed practitioners to practice under certain conduct guidelines and mandating the use of a Client Bill of Rights.
2. It is not an exclusive scope of practice law like other professional licensing laws and it does not exclude any practitioners from practicing.
3. It is a new model of law to address the needs of the people.

Instead today I would like to share with you, key issues that invariably come up in groups that come together to promote change in the world of healing. They are factors that I believe are important for local, state and federal groups to keep in mind when formulating decisions:

1.) Firstly and foremost, we must listen to the voice that is heralding the need for change. Listen and remember. Who is the voice, what is it saying? I hear one primary voice loud and clear. It is the voice of individuals in their healing journeys. Individuals want change, choice, information, options, and they want healing that resonates with their values, cultures, and physical, spiritual and emotional needs and they want to be a part of their health care decisions.

The collective voice of individuals has now become the whaling voice of survival. This voice must be listened to in any plan we make. This voice is the heart and soul of our country, it is the voice of the people.

Often individuals that have positive healing results ask the question...Why doesn't everybody know about this? They feel lucky. They are amazed at their own discovery of healing. Some of these individuals run into roadblocks such as those who lose their access to a product or a practitioner because the practitioner is prosecuted or disciplined or because the federal government prohibits a product. Others get harassed by their conventional medical care providers as having gone astray. A stark example of this is the recent New York case of

a mother who refused to give her oldest child Ritalin. She was reported to child protection and a court took, not only her oldest child away but her two younger children as well. These kinds of stories can turn a fairly passive individual into a passionate activist.

2.) Secondly, we must not only articulate the collective voice but we must really understand the root of the problem, the reasons for the problem. Health care advocacy groups must solicit expert advice to help understand the situation in its entirety. This is a step many groups misinterpret or simply skip until it is too late. The most common error is that health care groups begin by soliciting advice exclusively from health care practitioners and administrators rather than utilizing the broad range of health care experts able to speak to health care history, sociology, customs, economic structures, laws, regulations, and public policy and international impacts and more. Groups that are successful at creating long lasting recommendations necessarily will have brought all of these advisors to the table and have them be part of their leadership team.

Example of expert resources needed in this phase are historians, medical sociologists, cultural leaders, business analysts, lawyers and public policy analysts, and human rights and consumer advocacy leaders, private citizens and community leaders. The goal is to understand the history of the identified problem area, reasons for current public policy, the impact of healing roles within the culture, the politics of healing, and issues regarding economic delivery systems. Leaders must be able to make summary statements about regulations and laws, and how they work and what benefits and limitations they have to the public. In general, we must understand the path that brought us to the present moment so that we can contemplate wise recommendations for the future.

3.) Third, after research and study is completed and shared with the community, groups delegated to making recommendations for the future should be developed with inclusive representation. In practical terms for health advocacy groups, this often means having an increase in non-practitioner persons. This often does not happen because of existing political realities and power structures. Nevertheless inclusivity should be the goal since healing impacts all people, all races, creeds, genders, age and all walks of life. It is a community issue. Groups should reflect this community diversity and should include the community elders.

The following are types of voices that should be represented on a group making recommendations for change regarding healing: persons that are ill or recovering from illness, senior citizens, youth, parents, teachers, economists, entrepreneurs, information technology specialists, lawyers, business and public policy analysts, insurance representatives, community health leaders, people who are revered in their community as an elder, service providers for special populations, members equally from all races, healers from many cultures and traditions, licensed and unlicensed providers, health care community activists for rural, inner city, and data privacy, and government and religious leaders.

4.) Fourth, we must be open, as a group, to new and creative solutions that help us cope with the obvious shift in paradigm, the expansion of the understanding of healing itself. Yes, new solutions can be scary and require some risk taking. But that is the nature of change. That is also the nature of the healing process. Remember, we are healing our community.

If we proceed in the spirit of healing itself, we will be required to listen harder, put our special interests and pre-conceived notions behind, give up attitudes of exclusivity and competition, and like in healing, may even be required to admit that we no longer have the control we once thought we had. Instead we will receive power to choose our own destiny as individuals and as a community as well, and we will attain harmony. I believe we will arrive at the power of integrity, knowing that we are an important member of a special, inclusive, and thoughtful community.

Of course Minnesota knows that communities can bring about profound change regarding healing. There are many examples of this in Minnesota and the MN legislation is just one of them. For the legislation effort, it began with the large interdisciplinary study advisory council gathered together by the Department of Health in response to legislation, followed by years of health freedom discussion, politics, and advocacy.

We know it can be done. Yes, the solutions will be different for every group and for every state. But that is to be expected and contributes to pluralism and societal strength. Groups will assess their situation in the context of their own special healing culture.

5.) And finally, there is a need to address especially tough problems with everlasting compassion and creativity, even developing special think tanks and utilizing special mediators, elders, and problem-solvers to help come to resolutions of special issues. No one said healing was easy. We must be creative and courageous.

Rather than sharing with you my list of those tough problems that I see repeating themselves over and over across the United States, problems that will require more intensive problem solving skills, I would like to stick with comments about process.

I'd encourage the Commission to recommend the use of mediators and creative problem solvers and consultants to assist groups that are having special difficulty finding solutions to problems. Recommend that dialogue continue when it is apparent that the community is still substantially uncomfortable with the results of a recommendation. Encourage the continued creation of options instead of creating deadlines, giving up, making ultimatums, or closing doors. Keep the process fluid until we arrive at solutions that bring harmony to us all.

In Conclusion:

Healing impacts all peoples. The collective voice, a whaling for survival, has arisen heralding a need for immediate change in our country. We will be wise to listen to this voice carefully, discern what it is saying, and articulate the problem clearly before proceeding.

We must set to work with all of the resources we have to understand the reasons for the problem, consulting with elders and community leaders, historians, sociologists, law and

public policy analysts, and any other resources that we have to educate us about the nature and perspective of how we got to where we are today. Once we understand the problem, we must bring together a diverse inclusive community to develop recommendations for change. Because problems may be rooted in existing power structures and social and economic policies, groups must be encouraged to let go of preconceived notions and participate in new creative solutions, understanding that change may require some exploration and risk-taking just as the process of healing itself.

Everyone acknowledges that there are particularly persistent and difficult problems in the world of healing. We must encourage each other to proceed to make change in the spirit of healing, with everlasting compassion, and approach these problems with open hearts and minds. We must not be afraid to utilize every resource we have for resolution, mediation and problem solving. We must remember that it is possible to find a glorious balance between the yearning of the individual to have free choice, autonomy and integrity in healing and the responsibility of the community as government to protect the its members from harm.

Thank you for your consideration.

Diane M. Miller JD

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Rep Boudreau

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

Citizens have basic rights to make personal choices regarding their own health and well being and the constitutional right to access any health care practitioner, treatment or information source that 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.

The health freedom movement in Minnesota was galvanized a few years ago when alternative care practitioners both licensed and unlicensed were charged with practice of medicine without a license, despite the absence of any allegations of patient harm. The state's Medical Board sought to shut down these practitioners immediately and permanently.

The existing Mn Statute 147.081 has an overly broad definition of the practice of medicine which reads "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 without a license, and is guilty of a crime.

Tools that helped to guide us included:

Minnesota's Chapter 214 statutes which establishes policies for occupational regulation. The underlying tenant of Chapter 214 is that "The legislature declares that no regulation shall be imposed upon any occupation unless required for the safety and well-being of the citizens of the state.

A 1998 study conducted by the Minnesota Department of Health, directed by the legislature in 1997, which provided recommendations regarding Complementary and Alternative therapies. That study covered the types of therapies available in the state, the existing regulation of such, utilization, and possible regulation concepts.

A 1999 program evaluation by the Office of the Legislative Auditor which affirmed that the Chapter 214 standards should be applied more consistently before new regulation is to be enacted. "The fundamental requirement is to demonstrate that there is a significant threat to public health or safety from unregulated practice. The burden of proof is on the proponents to make the case that occupational regulation is needed and that the proposed regulation meets specific statutory criteria. Mn law requires the least restrictive form of regulation to be used if regulation is

necessary."

The Minnesota Complementary and Alternative Health Care Freedom of Access Act of 2000 passed last year and in the House and Senate and was signed by Governor Ventura. It will become law in July of this year. This did not happen without extensive debate, vehement opposition from many representing traditional medical interests, and persistent support from consumer advocates. Because the chair of Civil Law, Representative Steve Smith allowed well over 10 hours of committee time on this legislation, the bill was able to progress in design and support due to many changes. Not everyone was on board after passing through nine committees in the House and Senate, but the Board of Medical practice not longer opposed the bill.

The Freedom of Access Act created a new office in the MDH to provide government oversight of the practices of unlicensed complementary and alternative health care practitioners which will handle consumer complaints and enforce practitioner prohibited conduct.

The legislation protects consumer options while providing strong consumer protection by:

- * Assuring that all consumers receive notices and client bill of rights,

*Providing guidelines for practitioners by listing grounds for disciplinary actions and setting out what to include in the client bill of rights,

*Mandating that the Dept of Health report back to the Legislature within two year with information on the number and nature of complaints under the new office.

This bill creates good public policy by recognizing that there is a broad range of unlicensed healing systems and services that play an integral role in our community, and that by providing government oversight in these relationships between consumer and practitioners, the role of government is fulfilled.

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.**