Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. testimony	Gayle Bowler (partial) (1 page)	03/16/2001	b(6)
002. email	Gisela DiCarlo to WHCCAMP re Comments to the Commission (partial) (1 page)	02/27/2001	b(6)
003. email	Kay Eldrid to Senator Tom Harkin et al re Protocol Info (4 pages)	02/28/2001	b(6)
004. email	Kay Eldrid to Senator Tom Harkin et al re Montel Williams Letter (2 pages)	02/28/2001	b(6)

COLLECTION:

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

OA/Box Number: 43231

FOLDER TITLE:

WHCCAM Town Hall Meeting Testimony, Minneapolis, Minnesota, March 16, 2001
[Folder 1] [5]

2011-0568-S
kc803

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

White House Commission on Complementary and Alternative Medicine Policy
Minneapolis, Friday, March 16, 2001

Ike Rodman
Minnesota College of Acupuncture and Oriental Medicine
of Northwestern Health Sciences University
Bloomington, Minnesota

We in oriental medicine feel that use of acupuncture needles by practitioners who have not been trained in the complete paradigm subjects the public to ineffective treatment and *confuses the public* about what acupuncture and oriental medicine are.[1] This may be one result of naming the treatment for the tool, and leaving diagnosis, the heart of the medical care, out of the definition. There is confusion among Congress and third-party payers about qualifications of different providers who use acupuncture needles.

A bar to Congressional consideration of access to, and wider third-party reimbursement for, acupuncture and oriental medicine treatment is the lack of agreement among practitioners about who is competent to use acupuncture needles. In order to learn which providers are competent to help what patients, I **recommend** that a study be funded to compare courses of study and outcomes skills of AAMA and ACAOM-trained providers. Find the areas that are unique to each, the areas they have in common, and their levels of competency and safety. Practical clinical skills and patient outcomes must be assessed. This is not easy, but it will lead to understandings that will enhance possibilities of cost-effective integration of patient care.

For this study, you must find a committee of people with disparate views and interests. The members must all be strong people who will insist on the integrity of their paradigms, but who agree to agree on what can be agreed upon--people who can examine their own assumptions in good humor and appreciate the assumptions of others. This group will not be easy to find, but it must be found. A philosopher of language should perhaps be included because deciding upon definitions will be central.

I believe that mutual respect and increased referral will result. Whatever the results, I am ready for them in my belief in the value of the search for understanding.[2]

APPENDIX 1: NOTES

[1] There sometimes seems to be an assumption that CAM is an undifferentiated soup waiting for definition. It is important to understand that the profession of oriental medicine in the United States already has a professional structure, with national accreditation of master's-level education, national certification of competency, and state licensure and regulation of practice.

The oriental medicine schools and colleges are nationally accredited, state approved, degree-granting institutions of higher education offering first-professional master's degree programs.

The Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) is recognized by the U.S. Department of Education and by the Council on Higher Education Accreditation (CHEA).

The National Commission for Certification of Acupuncture and Oriental Medicine (NCCAOM), which gives national board exams, is a member of the National Organization for Competency Assurance (NOCA) and is accredited by the National Commission for Certifying Agencies (NCCA).

The practice of oriental medicine is licensed and regulated in most states, where it has been found to be safe and effective. Most states use the NCCAOM national board examination as part of their licensure requirements. I **recommend** that you view the licensure of oriental medicine practitioners as a states' rights issue the federal government should walk gently around.

Oriental medicine, with national standards for education and certification (national board exams), may be seen as a model for other CAM professions, but there are still different rules in each state. Practitioners across the country hunger for uniform national standards and reciprocity of licensure. Recognition by all states that national standards of accreditation and certification are the appropriate standards for education and licensure would greatly help practitioners who want to move to another state. The public too would be greatly helped in understanding what is available because titles and scopes of practice would be more uniform.

On the other side of the coin, practitioners who have been in practice for years are often prevented from moving from one state to another because they began to practice before national standards existed. Reciprocity of licensure should be encouraged. Because it is in the public interest, I **recommend** that the NIH's CCAM gather state regulators to discuss the feasibility of agreement on national standards and reciprocity of licensure.

Oriental medicine is, in the words of the Minnesota statute,

> a comprehensive system of health care using Oriental medical theory and its unique methods of diagnosis and treatment.

Many patients come to oriental medicine practitioners after exhausting standard treatment possibilities. Often these patients are the very ones oriental medicine treats best. That is, the systems really are complementary. They see the body and health with different metaphors and have different answers to questions that are conceived differently.

Because oriental medicine is a comprehensive system, the parts (the tools) are less effective than the application of the whole paradigm. Use of the tools without the paradigm *confuses the public*. Patients feel, for instance, that they have "had acupuncture," and it didn't help, so they do not seek a practitioner of oriental medicine who may be able to help.

[2] I **recommend** that after the study is completed, the federal government report to itself through the government printing office and make the reports available to the public to educate the public on modalities. I believe this report will show the breadth and depth of oriental medicine, and will help the public understand the difference between licensed oriental medicine and medical acupuncture.

APPENDIX 2

CLINICAL RESEARCH

Two models perhaps define the spectrum of research, with randomized double-blind clinical trials on one end, and Albert Einstein's thought experiments on the other. RCT were developed to test pharmaceuticals--single-agent medications for specific conditions. We who follow can surely think up something relevant and still "scientific" to test holistic medicine.

As a creative approach to cost-effective and ethically-perceptive research, I **recommend** that research be funded to scour patient records and compare outcomes to standard care. Many patients have exhausted standard care, so this study will be relatively easy for the some conditions.

Patient satisfaction surveys will be relevant. Patients are being helped. We need research because we all need information to help patients. I **recommend** that instead of waiting to see if research proposals come up to standard expectations, the CCAM meet with ACAOM schools to discuss creative ways OM can be investigated. Let's make this a mutual search for understanding rather than applying the same western scientific paradigms to OM. Work together for creative research design. We have the practice records. You have the research experience. Let's work together in our mutual quest for understanding.

APPENDIX 3: THE COMMISSION'S QUESTIONS

1. Coordinated Research and Development to Increase Knowledge of Complementary and Alternative Medicine Practices and Interventions.

> What can be done to expand the current research environment so that practices and interventions that lie outside conventional science are adequately and appropriately addressed?

A research database exists in the patient files of oriental medicine practitioners (called Licensed Acupuncturists in most states). These patient files should be surveyed and the outcomes compared to usual care. Many patients who come to oriental medicine come as a last resort after exhausting bio-medical treatments. The relief they experience as a result of oriental medicine treatment is often dramatic. These patient files are a natural for comparisons to standard care.

> What types of incentives are needed to stimulate the research of CAM practices and interventions by the public and private sectors?

We need creative ways of thinking that are designed to elicit information rather than to adhere rigidly to protocols that were developed for drug trials. Drugs are single refined ingredients produced for a single purpose. That is the opposite of holistic care, which looks for patterns of conditions in order to craft the most efficient treatment for the complex presented by a single patient on a particular day. Research should be relevant. The data exist in the patient files of practitioners. These data could be gathered and compared to standard care.

3. Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine.

> How can uniform standards of education, training, licensure and certification be applied to all CAM practitioners?

Uniform standards should not be applied. Relevant standards to protect the public should be applied, such as accreditation of schools, certification of competence of practitioners, and establishment of state boards to protect the public.

> What training and education should be required of all health care providers to assure access to safe and effective CAM practices and interventions?

APPROPRIATE training should be required for the scope of practice. Assurance of appropriate education and testing for professional competence are the areas of expertise of professional accreditation and certification commissions. In other words, the patterns exist. Do not seek to reinvent the wheel.

Gregory Schmidt, testimony for President's Commission on Complementary and Alternative Medicine Policy in Minneapolis, Minnesota March 16, 2001

My name is Gregory Schmidt. I am an artist, a carpenter and the vice president of the Minnesota Natural Health Legal Reform Project.

I am here because:
#1) I believe natural health practitioners recognize, in fact celebrate, the uniqueness of the individual and the body's own healing abilities, and because they recognize that we are not interchangeable machines with interchangeable parts.

#2) because I am ultimately responsible for my own health and well-being. I will be the judge of where I will go, what path I will choose and who I will work with in that pursuit.

I believe I am qualified to speak about these matters because I am a person and because it is we the people who should be in charge, not the associations, not the boards, not the schools, not the HMO's, not the doctors, not even the natural health practitioners. It should be WE THE PEOPLE.

I believe I am qualified to speak because my experiences in my degreed field and also in my business relate to two of the main questions that were constantly asked of us during our legislative endeavors.
#1)"Standards, what about standards?"
#2) Fairness, "Well, under this bill, anybody can just hang up a shingle and call themselves a natural health practitioner and all of these other professionals have all of this education,all of this training, and all of the liability, and is that fair?"

I believe I am qualified to speak because we the people did pass a bill that at least partially guaranteed our freedom of access.

The commission has asked us to present ideas on what we learned from that process and how to duplicate it. In other words, where do we go now.

QUESTIONS ABOUT STANDARDS:

Where did this seemingly unquestioning reverence for standards come from? Is it our birthright/responsibility as humans or is it a byproduct of the industrial age and machines and mass production and marketing?

My goal as an artist or a carpenter is to do the best I can, to treat others like I would like to be treated. It may sound quaint, but if I do not respect myself, my work, and my clients, and if humility, openness, fairness, honesty and love are not enough, how can one do more? I am six feet, two inches, and I will never be 6 foot 6 inches no matter how hard I try, how much education I get or what governing body may wish otherwise. Until people are standardized, I do not see how any relationships between them can be standardized, either. Each interaction is totally unique and special in it's own right.

REGARDING FAIRNESS:

THE FOCUS SHOULD BE ON THE CLIENT.This should not be about one group or belief or one's schooling verses another groups beliefs or schooling.

This reminds me of the story of the farmer who paid the workers hired later in the day the same as the workers hired earlier in the day even though the workers hired in the beginning of the day agreed to their wages. The workers hired in the beginning of the day complained that the workers hired later in the day earned they same pay and it was not fair. It is not about the pay or the work, it is about the commitment to help.

The focus should be, did the person get better? Not who helped them or how or by what method.

Maybe a lot of the problems we are seeing would be helped if practitioners only got paid for results. I know I do not get paid if I do not satisfy my customer. I have virtually no formal training as a carpenter, yet can honestly say that I am one of the most skilled in my field. Why? It is because of the respect I have for my clients, their investment and the work itself. I have never met a natural health practitioner who is not equally dedicated foremost to the clients interest.

Thank you.

DAMS, INC
LEO B CASHMAN, PRESIDENT
3236 17TH AVE S
MINNEAPOLIS, MN 55407

(800) 311-6265

To: White House Commission on Complementary and Alternative Medicine

Conventional dental practices have come under increasing scrutiny during the past decade by independent scientific investigators. I enclose a review article by Professors Loscheider, Vimy and Summers, which gently and convincingly explains many of the findings: dental amalgam fillings, which are 50% mercury, on not safe. The mercury used in dental fillings is not safe.

Toxic dentistry is regarded by many independent observers as the leading instance of iatrogenic illness, surpassing even "medical mistakes" and "side effects of properly prescribed drugs." Only examples of toxic dentistry include the use of nickel which, like mercury, is a neurotoxin and is carcinogenic. Other heavy metals that find their way into the mouth in dental work are chromium, copper, tin, zinc, cadmium, fluorides, palladium, titanium and thallium. Adding to this the impacts of root canals, which can be highly toxic, the effects of periodontal disease, which can be promoted by the amalgams and the health impacts of jawbone infections, which are always highly toxic.
The synergistic effects of these many sources of toxins and the infectious conditions means that dentistry can have profound health consequences.

Our best, most innovative dentists have responded by practicing medically sound dentistry; the best dentists regard dentistry as a branch of medicine, because of the interplay between what is happening in the mouth and in the rest of the body, including the brain. They are dubbed "biological" dentists or "holistic" dentists because they look at the underlying biological impacts and at the whole person. Such excellent dentists are in great demand and there are not enough of them.

But, there are two problems in ridding the world of toxic dentistry. One is that the state dental boards have often sat in a state of official denial as to the dire health consequences of toxic dentistry, refusing to investigate, for example, charges of mercury poisoning by unsafe amalgam removal practices while in the dental chair. As a result, the dental consumer feels that he/she receives no understanding from the state dental board, which is usually dominated by handpicked members of the American Dental Association, a private trade group. The second problem is that these same dental boards harass, intimidate and even pull the licenses of the more prominent, more outspoken holistic dentists. Dozens of top holistic dentists have been forced to spend hundreds of thousands of dollars and years of their lives in order to defend themselves from the unchecked powers of the dental board's complaint committee, which is able to meet in private and to operate with accountability to no one. Often the holistic dentist collaborates with a holistic doctor or naturopath, and those doctors also find themselves subject to harassment by the states' medical boards. As a result may states have lost their finest holistic MDs.

Solutions. Congress should hold hearings on the health harm inflicted on the public by mercury and other features of toxic dentistry. They should the harm done to people's mental and physical

health, and the damage done to children and to infants and the unborn. They should hear about the damage inflicted on the professional lives of many of our best dentists by unfair and unjust regulatory actions by the state boards.

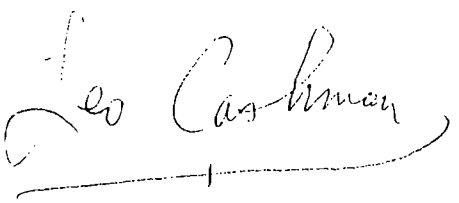
The Food and Drug Administration has a dental division which, ideally, should be curbing the use of amalgam fillings (as Canada has done) or imposing an outright ban (as Sweden has done). But our FDA's dental division has been dominated by the same ADA dentists that are the heart of the deception and cover-up. Congress and the president should rid the FDA of all who have conflicts of interest and appoint independent scientists and leaders whose commitment is only to the public health. Dental amalgams should be banned. Health plans and insurance companies should be prevented from forcing insured people to accept toxic dental options, and should be allowed to choose safer, more holistic dentists for their care.

Congress should establish a $200 million dollar fund as a preliminary measure, to pay for the safe replacement of amalgam fillings with biocompatible alternative materials. Since mercury has left many of its victims in ill health and financially devastated, the government, having failed to protect the public health in the past, should now make it possible for the victims to get their lives back. It should also fund new institutes for biological dentistry so that dentists can be re-trained to use safer materials and methods, and to replace the old amalgam fillings safely, without further poisoning the patient.

Congress should also conduct hearing on the scam of water fluoridation, which is mandatory in Minnesota and in many other states. It should investigate the corrupt politics of water fluoridation, which is a form of "mandatory medication," and which forces millions to drink and bath in the water to which the toxic byproducts from the phosphate fertilizer plants has been added (hydro-fluosilicic acid). The water fluoridation does not help dental status but does harm bones, connective tissue and brain and behavioral patterns.

The commission should take courage and represent people, rather than power. It should blow the whistle on the toxic dentistry, the fluoridation scam and the corrupt agencies and boards that help make this all possible. The commission's report will be heard by the congress and the American people, not just the president, and that will mobilize the demand for the change that is needed.

In ten days, on March 26th, Professor Fritz Lorscheider, PhD, will announce new research findings that further implicate dental mercury as the major cause of Alzheimer's Disease. Watch for that.



REVIEW

FASEB Journal 9(7) 1995 April 504-508
Vol 9, Number 7

Mercury exposure from "silver" tooth fillings: emerging evidence questions a traditional dental paradigm

FRITZ L. LORSCHEIDER,*,[1] MURRAY J. VIMY,† and ANNE O. SUMMERS‡

*Department of Medical Physiology and †Department of Medicine, Faculty of Medicine, University of Calgary, Alberta, T2N 4N1, Canada; and ‡Department of Microbiology, University of Georgia, Athens, Georgia, 30602.

Abstract: For more than 160 years dentistry has used silver amalgam, which contains approximately 50% Hg metal, as the preferred tooth filling material. During the past decade medical research has demonstrated that this Hg is continuously released as vapor into mouth air; then it is inhaled, absorbed into body tissues, oxidized to ionic Hg, and finally covalently bound to cell proteins. Animal and human experiments demonstrate that the uptake, tissue distribution, and excretion of amalgam Hg is significant, and that dental amalgam is the major contributing source to Hg body burden in humans. Current research on the pathophysiological effects of amalgam Hg has focused upon the immune system, renal system, oral and intestinal bacteria, reproductive system, and the central nervous system. Research evidence does not support the notion of amalgam safety.—Lorscheider, F. L., Vimy, M. J., Summers, A. O. Mercury exposure from "silver" tooth fillings: emerging evidence questions a traditional dental paradigm. *FASEB J.* 9, 504–508 (1995)

KeyWords: mercury toxicity · dental amalgam

HISTORICAL OVERVIEW OF MERCURY USE IN DENTISTRY

As early as the 7th century, the Chinese used a "silver paste" containing mercury (Hg) to fill decayed teeth. Throughout the Middle Ages, alchemists in China and Europe observed that this mysterious silvery liquid, extracted from cinnabar ore, was volatile and would quickly disappear as a vapor when mildly heated. Alchemists were fascinated that at room temperature Hg appeared to "dissolve" powders of other metals such as silver, tin, and copper. By the early 1800s, the use of a Hg/silver paste as a tooth filling material was being popularized in England and France and it was eventually introduced into North America in the 1830s. Some early dental practitioners expressed concerns that the Hg/silver mixture (amalgam) expanded after setting, frequently fracturing the tooth or protruding above the cavity preparation, and thereby prevented proper jaw closure. Other dentists were concerned about mercurial poisoning, because it was already widely recognized that Hg exposure resulted in many overt side effects, including dementia and loss of motor coordination. By 1845, as a reflection of these concerns, the American Society of Dental Surgeons and several affiliated regional dental societies adopted a resolution that members sign a pledge not to use amalgam. Consequently, during the next decade some members of the society were suspended for the malpractice of using amalgam. But the advocates of amalgam eventually prevailed and membership in the American Society of Dental Surgeons declined, forcing it to disband in 1856. In its place arose the American Dental Association, founded in 1859, based on the advocacy of amalgam as a safe and desirable tooth filling material. Shortly thereafter, tin was added to the Hg/silver paste to counteract the expansion properties of the previous amalgam formula (1–3).

There were compelling economic reasons for promoting dental amalgam as a replacement for the other common filling materials of the day such as cement, lead, gold, and tinfoil. Amalgam's introduction meant that dental care would now be within the financial means of a much wider sector of the population, and because amalgam was simple and easy to use, dentists could readily be trained to treat the anticipated large number of new patients. By 1895, the dental amalgam mixture of metals had been modified further to control for expansion and contraction, and the basic formula has remained essentially unchanged since then (2, 3). Scientific concerns about amalgam safety initially surfaced in Germany during the 1920s, but eventually subsided without a clear resolution. At the present time, based on 1992 dental manufacturer specifications, amalgam (at mixing) typically contains approximately 50% metallic Hg, 35% silver, 9% tin, 6% copper, and a trace of zinc. Estimates of annual Hg usage by U.S. dentists range from approximately 100,000 kg in the 1970s to 70,000 kg today. Hg fillings continue to remain the material preferred by 92% of U.S. dentists for restoring posterior teeth (4,5). More than 100 million Hg fillings are placed each year in the U.S. Presently, organized dentistry has countered the controversy surrounding the use of Hg fillings by claiming that Hg reacts with the other amalgam metals to form a "biologically inactive substance" and by observing that dentists have not reported any adverse side effects in patients. Long-term use and popularity also continue to be offered as evidence of amalgam safety (6).

In light of the medical research evidence that has accumulated primarily over the past decade, the purpose of this review is to examine the traditional dental paradigm that maintains that amalgam is a biologically safe and appropriate tooth restorative material.

MERCURY EXPOSURE FROM AMALGAM FILLINGS

During the early 1980s several laboratories established that Hg vapor (Hg^0) is continuously released from amalgam tooth fillings, and that the rate of release into human mouth air is increased immediately after chewing (7–9) or tooth brushing (10). Mouth air levels of Hg^0 correlate significantly with the number of occlusal (biting) amalgam surfaces in molar teeth. Continuous chewing for 10–30 min results in a sustained elevation of the mouth Hg^0 level, which eventually declines to a baseline level 90 min

[1]To whom correspondence should be addressed, at Department of Medical Physiology, Faculty of Medicine, University of Calgary, 3330 Hospital Dr. NW, Calgary, Alberta, Canada T2N 4N1.07O

0892-6638/95/0009-0504/$01.50.

after chewing cessation (11). Blood Hg levels also display a positive correlation with the number and total surface area of amalgam fillings (12).

A single amalgam filling with an average surface area of only 0.4 cm^2 is estimated to release as much as 15 μg Hg/day primarily through mechanical wear and evaporation, but also through dissolution into saliva (13). Recent electron microscopy images and electrochemistry data show direct evidence of amalgam Hg corrosion and leakage into saliva as free ions (14). Thus, for an average individual with eight occlusal amalgam fillings (11), a total of 120 μg Hg could be released daily into the mouth and a portion of this amount would be inhaled or swallowed. These estimations are consistent with a recent report showing that human subjects with an average number of amalgam fillings excrete approximately 60 μg Hg/day in feces (15), a portion of which is microparticles of amalgam. Various laboratories have estimated that the average daily body absorption of amalgam Hg in humans ranges between 1.2 and 27 μg (16), with levels for some individual subjects being as high as 100 μg/day. At the present time the consensus average estimate is 10 μg of amalgam Hg (range 3–17 μg) absorbed per day (17), an uptake amount corroborated by a more recent daily estimate of 12 μg (15). By way of contrast, estimates of the daily absorption of all forms of Hg from fish and seafood is 2.3 μg, and from other foods, air, and water is 0.3 μg (17). Thus, it is now proposed that dental amalgam tooth fillings are the major source of Hg exposure for the general population (17, 18). This position has been clearly validated by a recent demonstration that at least 65% of excretable Hg in human urine is derived solely from dental amalgams, and that amounts of Hg excreted also correlate with total amalgam surface area (19).

BODY TISSUE UPTAKE OF AMALGAM MERCURY

The degree to which body tissues can sequester amalgam Hg after exposure has been demonstrated in a variety of human and animal experiments. Human autopsy studies reveal significantly higher Hg concentrations in brain and kidney of subjects with aged amalgam fillings than in subjects who had no amalgam tooth restorations (20). When amalgam fillings containing a radioactive Hg tracer were placed in sheep molar teeth, a whole-body image scan performed 4 wk later demonstrated several possible uptake sites for Hg including oral tissues, jaw bone, lung, and gastrointestinal tract, with major localization of Hg in the kidney and liver (21). A similar whole-body image study repeated in a monkey (whose teeth, diet, feeding regimen, and chewing pattern more closely resemble those of humans) clearly demonstrates high levels of amalgam Hg in kidney, intestinal tract, and other tissues. The brain/CSF Hg ratio had increased threefold by 4 wk after amalgam fillings had been installed (22). The primate kidney will continue to accumulate amalgam Hg for at least 1 year after installation of such fillings (23).

Repeated observations in adult sheep (21, 24) demonstrate that after placement of amalgam fillings the blood Hg levels remain relatively low even though the surrounding body tissue concentrations of Hg become many fold higher than blood. This suggests that tissues rapidly sequester amalgam Hg at a rate equivalent to its initial appearance in the circulation. Such a phenomenon may explain why monitoring blood levels of Hg in humans is a poor indicator of the actual tissue body burden directly attributable to continuous low-dose Hg exposure from amalgam.

In pregnant sheep, which received amalgam fillings containing a radioactive Hg tracer, it was demonstrated that both maternal and fetal tissues began to accumulate amalgam Hg within several days after such fillings were installed. Maternal-fetal transfer of amalgam Hg was progressive with advancing gestation, and amalgam Hg also transferred to breast milk postpartum (24). More recently, human fetal/neonatal studies have likewise demonstrated that Hg concentrations in fetal kidney and liver, and cerebral cortex of infants, correlate significantly with the number of amalgam filled teeth of their mothers (25). This latter finding is consistent with previous animal studies that show greater Hg concentration in rat fetal tissues (and less placental retention) when the source of exposure was Hg^0 rather than mercuric salts (26).

CELL METABOLISM OF MERCURY

Major metabolic pathways

Figure 1 illustrates the major metabolic pathways for the three species of Hg. The principal source of Hg^0 is vapor from dental amalgam tooth fillings, whereas organic Hg (Hg^+) is derived principally from fish and seafood, and inorganic Hg (Hg^{2+}) originates from other foods, water, and air. Approximately 80% of inhaled Hg^0 is absorbed across the lung and converted to Hg^{2+} intracellularly by catalase oxidation. In contrast to other Hg species, the high lipid solubility of Hg^0 permits it to cross cell membranes readily, including the blood–brain barrier, and easily enter the brain. However, the kidney eventually becomes the major site of Hg accumulation during compartmental redistribution after exposure to Hg^0. Some Hg^0 is also dissolved in saliva and swallowed, converted to Hg^{2+} by peroxidase oxidation, and the majority is eliminated by fecal excretion. Other Hg^{2+} that is ingested in the diet is poorly absorbed across the intestinal tract and most is excreted in the feces. Although the majority of Hg^+ from the diet is also eliminated in the feces, a substantial portion is absorbed intracellularly as methyl-Hg^+. Both intracellular Hg^{2+} and Hg^+ are ultimately bound covalently to glutathione (GSH) and protein cysteine groups. Hg^{2+} is the toxic product responsible for the adverse effects of inhaled Hg^0. Body tissues have various retention half-lives for Hg^+ and Hg^{2+} ranging from days to years (15, 17, 26–28). After Hg is released from tissues, fecal excretion becomes the predominant route for elimination of Hg from the body. Human fecal excretion of

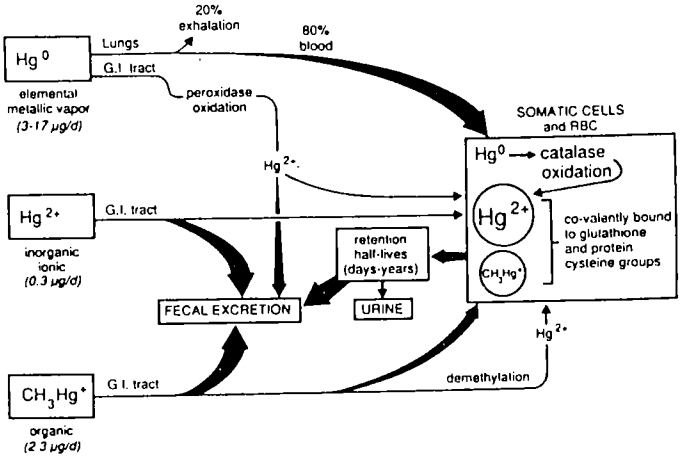


Figure 1. Metabolism of mercury species.

Hg correlates significantly with the number of amalgam fillings, and the excretion rate for Hg in feces is 20 times higher than its corresponding excretion rate in urine. Even though fecal excretion of amalgam Hg predominates, this principal excretory route in humans shows a high correlation with urinary excretion of Hg. Fecal excretion rates for Hg in human subjects with amalgam tooth fillings can be as much as 100-fold higher than in subjects without such fillings (15).

Significance of glutathione and other sulfhydryl compounds

The major low molecular weight sulfhydryl compound in mammals is GSH, present at approximately 5 mM in cells, serum, and bile (29). Other low molecular weight sulfhydryls present at lower concentrations in cells include cysteine, biotin, lipoic acid, and coenzyme A. The major targets in proteins for binding of transition metals, including Hg, are the sulfhydryl group of cysteine and the imino nitrogen of histidine. The aromatic ring nitrogens of the nucleotide bases also form Hg complexes, with thymine and uracil being more reactive than cytosine, guanine, and adenine (30).

Whereas Hg^0 from amalgam is lipid soluble and freely passes through cell membranes, methyl and ionic Hg from food and other sources are both charged and therefore must be complexed with counter-ions or low molecular weight sulfur compounds in order to pass freely through the cell membrane.

The major cellular reaction potentiating the toxicity of Hg^0 is its oxidation by catalase, an enzyme found in all normal mammalian cells (31). This oxidation process can take place in any of the "barrier tissues" of the body as well as in the blood. Once generated within the cell by catalase, highly reactive Hg^{2+} will interact with a variety of nucleophilic ligands, the most abundant single nucleophile reactant being GSH. The sulfhydryl groups of proteins are next in abundance and avidity for Hg^{2+}, with the imino nitrogens of histidine and the nucleobases being substantially less reactive.

Despite the large molar excess of GSH, many proteins compete very effectively for binding of transition metals such as Zn, Ni, and Cu. The precise chemical basis for the high affinity of such metalloproteins is not understood; many of the currently well-defined members of this group, including important regulatory proteins, use cysteines and histidines as ligands to their respective metal cofactors (32). Thus, these proteins may exchange metals, including Hg, bound to GSH.

Once bound to GSH, Hg can leave the cell to circulate in serum or lymph and be deposited in other organs or tissues. GS-Hg-SG is eventually eliminated via either the kidney or downloaded via bile into the intestinal lumen and excreted in feces. After Hg leaves cells, its major route of elimination in any form (inorganic or organic) is via feces, with less than 10% of Hg normally exiting the body in urine (26). Experiments in sheep (21, 24) and monkey (22) indicate that 99% of amalgam Hg is excreted in feces, and in humans with 30 amalgam surfaces the average 24 h excretion rate for Hg in feces is 60 μg (95% of total daily excretable Hg) in contrast to 3 μg/24 h in urine (15). In mammals, half-lives from acute single doses of Hg^{2+} or methyl-Hg^+ range from months to years. Half-lives may differ with chronic Hg exposure as a result of compromised cellular function (e.g. kidney Hg turnover deceases with age and duration of exposure) (17, 26).

EFFECTS OF AMALGAM MERCURY ON CELL AND ORGAN SYSTEM FUNCTION

The overt clinical effects resulting from toxic exposure to the three species of Hg have been described (26, 28). Various animal and human experiments over the past several years have addressed the possibility of more subtle pathophysiological effects of amalgam Hg upon the function of several organ systems or cell types, including the immune system, renal system, oral and intestinal bacteria, reproductive system, and central nervous system.

Immune system

Ionic Hg has been shown to be antigenic and capable of inducing autoimmunity in rats (33, 34). In a very recent report, gelatin-encapsulated dental amalgam pieces were implanted intraperitoneally in an inbred strain of mice known to be genetically susceptible to Hg-induced immune pathology. Within 10 wk to 6 months the animals displayed hyperimmunoglobulinemia, serum autoantibodies that targeted nucleolar proteins, and systemic immune complex deposits. Similar changes were observed when only dental alloy (not containing Hg) was implanted, and these immune aberrations were attributed to the silver component of the alloy. This study concluded that both Hg and silver dissolution from dental amalgam can chronically stimulate the mouse immune system with subsequent induction of systemic autoimmunity (35). In humans, fecal excretion of silver is also correlated with the number of amalgam fillings (15). This would suggest that further investigation of the potential molecular effects of amalgam metals on the human immune system is warranted.

Renal system

Because human (20), monkey (22, 23), and sheep (21) kidney display significantly increased Hg concentrations after exposure to dental amalgam, some investigations have focused on what these concentrations may imply for renal function. Sheep with amalgam tooth filling implants show a reduced filtration rate of inulin, increased urinary excretion of sodium, and a decrease in urinary albumin (36). An increased sodium excretion has also been observed in monkeys similarly treated with amalgam fillings (unpublished data). Because Hg^{2+} accumulates primarily in the proximal tubule of rat (37) and rabbit (38) kidney and amalgam Hg in the proximal tubule of monkey kidney (23), where the majority of sodium is normally reabsorbed, increased excretion of sodium after placement of amalgam fillings in sheep (36) may reflect a reduced tubular capacity to conserve sodium selectively. Urinary albumin levels increased 1 year after removal of amalgam fillings in humans (12), whereas urine albumin levels fell in sheep after amalgam placement (36). It is uncertain whether these differences in albumin excretion patterns may reflect a Hg-induced reduction in renal blood flow due to the presence of amalgam fillings.

Oral and intestinal bacteria

It is well established that some human intestinal bacteria carry plasmids encoding resistance to both Hg and antibiotics (39). In a population subgroup of 356 persons who had no recent antibiotic exposure, those individuals with a high prevalence of Hg resistant bacteria in their intestinal flora were significantly more likely to display multiple antibiotic resistance in these same bacteria. A parallel investigation in monkeys demonstrated a marked in-

crease in the proportion of Hg-resistant bacteria in the floras of the intestine and oral cavity soon after installation of dental amalgam tooth fillings, an increase that persisted until the amalgam fillings were removed. The majority of these primate Hg resistant bacteria were also resistant to one or more commonly used antibiotics. Results show that Hg released from dental amalgam can enhance the prevalence of resistance to multiple antibiotics in the bacteria of the primate normal flora (40).

Reproductive system

The relationship of occupational exposure to Hg^0 and fertility of female dental assistants has recently been examined, because it is well established that long-term exposure to Hg^{2+} will alter reproductive cyclicity in rodents. Epidemiological screening by questionnaire of 7000 dental assistants showed that within an eligible subgroup of 418 women who were subsequently interviewed, fertility was reduced to only 63% that of control women not occupationally exposed to Hg^0. The study, while open to the criticism of all data that rely upon subject observation and opinion, concluded that dental assistants who prepared 30 or more amalgam fillings per week, and who also had poor Hg hygiene habits, were at risk of lowered fecundity (41).

Central nervous system

Initially suggestions occurred within medicine that neurodegenerative diseases could perhaps be linked to Hg from dental amalgam, but no experimental evidence was available at that time (42). However, it is now established that uptake and accumulation of amalgam Hg occur in monkey and human brain tissues (22, 27). Studies have demonstrated that Hg is selectively concentrated in human brain regions (medial basal nucleus, amygdala, and hippocampus) involved with memory function, and have suggested that Hg may be implicated (by mechanisms as yet unexplained) in the etiology of Alzheimer's disease (AD) (43, 44). Abnormal microtubule formation in AD brains has been associated with a defect in the tubulin polymerization cycle (45), which may increase the density of neurofibrillary tangles. A similar tubulin defect can be induced in the brain of $HgCl_2$-treated rats (46, 47), suggesting a connection between exposure to inorganic Hg and AD. $HgCl_2$ also markedly inhibits in vivo ADP-ribosylation of two rat brain cytoskeletal proteins, tubulin and actin, and thus alters a specific neurochemical reaction involved in maintaining brain neuron structure (48).

It is well established that Hg^+ will interact with tubulin resulting in disassembly of microtubules, and that microtubules function to maintain neurite structure (49). In a current investigation, recently reported, rats were exposed to Hg^0 4 h/day for as long as 14 consecutive days. Vapor exposure was maintained at 300 μg Hg/m^3 air, a level detectable in mouths of some human subjects with large numbers of amalgam fillings. Average brain Hg concentrations increased significantly with duration of Hg^0 exposure. Photoaffinity labeling of the β-subunit of the tubulin dimer with $[\alpha^{32}P]8N_3GTP$ in brain homogenates was diminished by 75% after 14 days of Hg^0 exposure. An identical neurochemical lesion of similar magnitude was seen in human AD brain homogenates, but no direct evidence exists to prove that this lesion is the result of human exposure specifically to amalgam Hg. Because the rate of tubulin polymerization is dependent on binding of tubulin dimers to GTP, it was concluded that chronic inhalation of low-level Hg^0 in rats can inhibit the polymerization of tubulin essential for formation of microtubules (50).

Another recent report demonstrates subclinical neuropsychological and motor control effects from an occupational exposure to Hg^0 over 1 year in a subpopulation of dentists with high urinary Hg levels (51). A more extensive report, evaluating dental technicians and dentists who received occupational exposure to Hg^0 and nondental personnel controls, demonstrated that after a chelation drug (DMPS) challenge test urinary Hg levels were 16-fold higher in technicians and 6-fold higher in dentists compared to control subjects. Baseline urinary porphyrin levels measured before DMPS treatment were associated with urinary Hg levels obtained after the DMPS challenge. Urinary Hg was also adversely associated with several neurobehavioral changes in Hg-exposed subjects including impairment of attention tasks and motor perceptual tasks. The utility of a DMPS challenge to assess renal Hg burden was established (52).

CONCLUSIONS

The collective results of numerous research investigations over the past decade clearly demonstrate that the continuous release of Hg^0 from dental amalgam tooth fillings provides the major contribution to Hg body burden. The experimental evidence indicates that amalgam Hg has the potential to induce cell or organ pathophysiology. At the very least, the traditional dental paradigm, that amalgam is a chemically stable tooth restorative material and that the release of Hg from this material is insignificant, is without foundation. One dental authority states that materials are presently available that are suitable alternatives to Hg fillings (4). Based on recent immunology investigations (35), electrochemical corrosion experiments (14), and human metabolic studies (15) it appears that the use of silver in amalgam may be almost as questionable as is Hg, and this evidence suggests that it may be inappropriate to alternatively use recently developed Hg-free silver-containing dental metals (53) to fill teeth. It would seem that now is the time for dentistry to use composite (polymeric and ceramic) alternatives (4) and discard the metal alchemy bestowed on its profession from a less enlightened era. Although human experimental evidence is incomplete at the present time, the recent medical research findings presented herein strongly contradict the unsubstantiated opinions pronounced by various dental associations and related trade organizations, who offer assurances of amalgam safety to dental personnel and their patients without providing hard scientific data, including animal, cellular and molecular evidence, to support their claims (54). FJ

The authors thank the Wallace Genetic Foundation, the International Academy of Oral Medicine and Toxicology, the University of Georgia Research Foundation, and the National Institutes of Health, whose support of research contained in a number of the citations herein made this review possible.

REFERENCES

1. American Academy of Dental Science. (1876) *A History of Dental and Oral Science in America* (Dexter, J.E., ed) S.S. White Publ., Philadelphia
2. Bremner, M.D.K. (1954) *The Story of Dentistry, 3rd Ed.*, Dental Items of Interest Publ. Co., Brooklyn
3. Ring, M.E. (1985) *Dentistry: An Illustrated History.* H.N. Abrams Inc. Publ., New York

4. Reinhardt, J.W. (1988) Risk assessment of mercury exposure from dental amalgams. *J. Pub. Hlth. Dent.* **48,** 172–177
5. Berry, T.G., Nicholson, J. and Troendle, K. (1994) Almost two centuries with amalgam: Where are we today? *J. Am. Dent. Assn.* **125,** 392–399
6. American Dental Association Divisions of Communication and Scientific Affairs (1990) When your patients ask about mercury in amalgam. *J. Am. Dent. Assn.* **120,** 395–398
7. Svare, C.W., Peterson, L.C., Reinhardt, J.W., Boyer, D.B., Frank, C.W., Gay, D.D. and Cox, R.D. (1981) The effects of dental amalgams on mercury levels in expired air. *J. Dent. Res.* **60,** 1668–1671
8. Vimy, M.J. and Lorscheider, F.L. (1985) Intra-oral air mercury released from dental amalgam. *J. Dent. Res.* **64,** 1069–1071
9. Aronsson, A.M., Lind, B., Nylander, M., and Nordberg, M. (1989) Dental amalgam and mercury. *Biol. Metals* **2,** 25–30
10. Patterson, J.E., Weissberg, B., and Dennison, P.J. (1985) Mercury in human breath from dental amalgam. *Bull. Environ. Contam. Toxicol.* **34,** 459–468
11. Vimy, M.J., and Lorscheider, F.L. (1985) Serial measurements of intra-oral air mercury: Estimation of daily dose from dental amalgam. *J. Dent. Res.* **64,** 1072–1075
12. Molin, M., Bergman, B., Marklund, S.L., Schutz, A., and Skerfving, S. (1990) Mercury, selenium and glutathione peroxidase before and after amalgam removal in man. *Acta Odontol. Scand.* **48,** 189–202
13. Gross, M.J., and Harrison, J.A. (1989) Some electrochemical features of the *in vivo* corrosion of dental amalgams. *J. Appl. Electrochem.* **19,** 301–310
14. Masi, J.V. (1995) Corrosion of amalgams in restorative materials: the problem and the promise. In *Status Quo and Perspectives of Amalgam and other Dental Materials* (Friberg, L., Schrauzer, G. N., eds) Thieme-Verlag, Stuttgart. In press
15. Skare, I., and Engqvist, A. (1994) Human exposure to mercury and silver released from dental amalgam restorations. *Arch. Environ. Hlth.* **49,** 384–394
16. Vimy, M.J., and Lorscheider, F.L. (1990) Dental amalgam mercury daily dose estimated from intra-oral vapor measurements: A predictor of mercury accumulation in human tissues. *J. Trace Elem. Exp. Med.* **3,** 111–123
17. World Health Organization (1991) *Environmental Health Criteria 118, Inorganic Mercury* (Friberg, L., ed) WHO, Geneva
18. Clarkson, T.W., Friberg, L., Hursh, J.B., and Nylander, M. (1988) The prediction of intake of mercury vapor from amalgams. In *Biological Monitoring of Toxic Metals* (Clarkson, T.W., Friberg, L., Nordberg, G.F., and Sager, P.R., eds) pp. 247–260. Plenum, New York
19. Aposhian, H.V., Bruce, D.C., Alter, W., Dart, R.C., Hurlbut, K.M., and Aposhian, M.M. (1992) Urinary mercury after administration of DMPS: correlation with dental amalgam score. *FASEB J.* **6,** 2472–2476
20. Nylander, M., Friberg, L., and Lind, B. (1987) Mercury concentrations in the human brain and kidneys in relation to exposure from dental amalgam fillings. *Swed. Dent. J.* **11,** 179–187
21. Hahn, L.J., Kloiber, R., Vimy, M.J., Takahashi, Y., and Lorscheider, F.L. (1989) Dental "silver" tooth fillings: A source of mercury exposure revealed by whole-body image scan and tissue analysis. *FASEB J.* **3,** 2641–2646
22. Hahn, L.J., Kloiber, R., Leininger, R.W., Vimy, M.J., and Lorscheider, F.L. (1990) Whole-body imaging of the distribution of mercury released from dental fillings into monkey tissues. *FASEB J.* **4,** 3256–3260
23. Danscher, G., Hørsted-Bindslev, P., and Rungby, J. (1990) Traces of mercury in organs from primates with amalgam fillings. *Exp. Mol. Pathol.* **52,** 291–299
24. Vimy, M.J., Takahashi, Y., and Lorscheider, F.L. (1990) Maternal-fetal distribution of mercury (203-Hg) released from dental amalgam fillings. *Am. J. Physiol.* **258,** R939–R945
25. Drasch, G., Schupp, I., Höfl, H., Reinke, R., and Roider, G. (1994) Mercury burden of human fetal and infant tissues. *Eur. J. Pediat.* **153,** 607–610
26. Clarkson, T.W., Hursh, J.B., Sager, P.R., and Syversen, T.L.M. (1988) Mercury. In *Biological Monitoring of Toxic Metals* (Clarkson, T.W., Friberg, L., Nordberg, G.F., and Sager, P.R., eds) pp. 199–246. Plenum, New York
27. Goering, P.L., Galloway, D.W., Clarkson, T.W., Lorscheider, F.L., Berlin, M., and Rowland, A.S. (1992) Toxicity assessment of mercury vapor from dental amalgams. *Fundam. Appl. Toxicol.* **19,** 319–329
28. Klaassen, C.D. (1990) Heavy metals and heavy-metal antagonists. In *The Pharmacological Basis of Therapeutics, 8th Ed.* (Gilman, A.G., Rall, T.W., Nies, A.S., and Taylor, P., eds) pp. 1598–1602, Pergamon Press, New York
29. Meister, A., and Anderson, M.E. (1983) Glutathione. *Ann. Rev. Biochem.* **52,** 711–760
30. Bloomfield, V.A., Crothers, D.M., and Tinoco, I., Jr. (1974) *Physical Chemistry Nucleic Acids,* pp. 420–429, Harper & Row Publ., New York
31. Magos, L., Halbach, S., and Clarkson, T.W. (1978) Role of catalase in the oxidation of mercury vapor. *Biochem. Pharmacol.* **27,** 1373–1377
32. O'Halloran, T.V. (1993) Transition metals in control of gene expression. *Science* **261,** 715–725
33. Druet, P., Bernard, A., Hirsch, F., Weening, J.J., Gengoux, P., Mahieu, P., and Berkeland, S. (1982) Immunologically mediated glomerulonephritis induced by heavy metals. *Arch. Toxicol.* **50,** 187–194
34. Hirsch, F., Kuhn, J., Ventura, M., Vial, M-C., Fournie, G., and Druet, P. (1986) Autoimmunity induced by $HgCl_2$ in Brown-Norway rats. I. Production of monoclonal antibodies. *J. Immunol.* **136,** 3272–3276
35. Hultman, P., Johansson, U., Turley, S.J., Lindh, U., Enestrom, S., and Pollard, K.M. (1994) Adverse immunological effects and autoimmunity induced by dental amalgam and alloy in mice. *FASEB J.* **8,** 1183–1190
36. Boyd, N.D., Benediktsson, H., Vimy, M.J., Hooper, D.E., and Lorscheider, F.L. (1991) Mercury from dental "silver" tooth fillings impairs sheep kidney function. *Am. J. Physiol.* **261,** R1010–R1014
37. Zalups, R.K. (1991) Autometallographic localization of inorganic mercury in the kidneys of rats: Effect of unilateral nephrectomy and compensatory renal growth. *Exp. Mol. Pathol.* **54,** 10–21
38. Zalups, R.K., and Barfuss, D.W. (1990) Accumulation of inorganic mercury along the renal proximal tubule of the rabbit. *Toxicol. Appl. Pharmacol.* **106,** 245–253
39. Gilbert, M.P., and Summers, A.O. (1988) The distribution and divergence of DNA sequences related to the Tn21 and Tn501 mer operons. *Plasmid* **20,** 127–136
40. Summers, A.O., Wireman, J., Vimy, M.J., Lorscheider, F.L., Marshall, B., Levy, S.B., Bennett, S., and Billard, L. (1993) Mercury released from dental "silver" fillings provokes an increase in mercury- and antibiotic-resistant bacteria in oral and intestinal floras of primates. *Antimicrob. Agents & Chemother.* **37,** 825–834
41. Rowland, A.S., Baird, D.D., Weinberg, C.R., Shore, D.L. Shy, C.M., and Wilcox, A.J. (1994) The effect of occupational exposure to mercury vapour on the fertility of female dental assistants. *Occup. Environ. Med.* **51,** 28–34
42. Ingalls, T.H. (1983) Epidemiology, etiology and prevention of multiple sclerosis. *Am. J. Forensic Med. Path.* **4,** 55–61
43. Thompson, C.M., Markesbery, W.R., Ehmann, W.D., Mao, Y.-X. and Vance, D.E. (1988) Regional brain trace-element studies in Alzheimer's disease. *Neurotoxicology* **9,** 1–7
44. Wenstrup, D., Ehmann, W.D., and Markesbery, W.R. (1990) Trace element imbalances in isolated subcellular fractions of Alzheimer's disease brains. *Brain Res.* **533,** 125–131
45. Khatoon, S., Campbell, S.R., Haley, B.E., and Slevin, J.T. (1989) Aberrant guanosine triphosphate-β-tubulin interaction in Alzheimer's disease. *Ann. Neurol.* **26,** 210–215
46. Duhr, E., Pendergrass, C., Kasarskis, E., Slevin, J., and Haley, B. (1991) Hg^{2+} induces GTP-tubulin interactions in rat brain similar to those observed in Alzheimer's disease. *FASEB J.* **5,** A456
47. Duhr, E.F., Pendergrass, J.C., Slevin, J.T. and Haley, B.E. (1993) HgEDTA complex inhibits GTP interactions with the E-site of brain β-tubulin. *Toxicol. Appl. Pharmacol.* **122,** 273–280
48. Palkiewicz, P., Zwiers, H., and Lorscheider, F.L. (1994) ADP-ribosylation of brain neuronal proteins is altered by *in vitro* and *in vivo* exposure to inorganic mercury. *J. Neurochem.* **62,** 2049–2052
49. Falconer, M.M., Vaillant, A., Reuhl, K.R., Laferriere, N., and Brown, D.L. (1994) The molecular basis of microtubule stability in neurons. *Neurotoxicology,* **15,** 109–122
50. Lorscheider, F.L., Vimy, M.J., Pendergrass, J.C., and Haley, B.E. (1994) Toxicity of ionic mercury and elemental mercury vapor on brain neuronal protein metabolism. 12th International Neurotoxicology Conference, Hot Springs, AR, October 31, 1994. *Neurotoxicology,* **15,** 955
51. Escheverria, D., Heyer, N., Martin, M.D., Naleway, C.A., Woods, J.S., and Bittner, A.C. (1995) Behavioral effects of low level exposure to Hg^0 among dentists. *Neurotoxicol. Teratol.* **17,** 161–168
52. Gonzalez-Ramirez, D., Maiorino, R.M., Zuniga-Charles, M., Xu, Z., Hurlbut, K.M., Junco-Munoz, P., Aposhian, M.M., Dart, R.C., Gama, J.H.D., Escheverria, D., Woods, J.S., and Aposhian, H.V. (1995) Sodium 2,3-dimercaptopropane-1-sulfonate (DMPS) challenge test for mercury in humans: II — Urinary mercury, porphyrins and neurobehavioral changes of dental workers in Monterrey, Mexico. *J. Pharmacol. Exp. Ther.* **272,** 264–274
53. Dariel, M.P., Lashmore, D.S., and Ratzker, M. (1994) New technology for mercury free metallic dental restorative alloys. *Powder Metallurgy,* **37,** 88
54. Lorscheider, F.L., and Vimy, M.J. (1993) Evaluation of the safety issue of mercury release from dental fillings. *FASEB J.* **7,** 1432–1433

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. testimony	Gayle Bowler (partial) (1 page)	03/16/2001	b(6)

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

OA/Box Number: 43231

FOLDER TITLE:
WHCCAM Town Hall Meeting Testimony, Minneapolis, Minnesota, March 16, 2001
[Folder 1] [5]

2011-0568-S
kc803

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

[001]

Testimony

White House Commission
3/16/01
Minneapolis Minnesota

From: Gayle Bowler
(b)(6)
Jordan, Minnesota 55352
bowlerg@minn.net

My name is Gayle Bowler. I am a satisfied consumer of several alternative modalities. Please protect my right to choose and the right to get information about those treatments.

The problems I encountered in my healing journey are what I hope lawmakers will protect other health seekers from. There was a period when a local dentist and homeopath were being harassed in a manner with lots of publicity and no unsatisfied clients. This put me in fear of discussing my treatment plan with my MD. Would my traditional doctor set in motion political terrorism of my herbalist? As I participated in a class of energy healing, the MD sitting next to me said he would lose his license if his colleagues saw him there. Licensed doctors should be allowed to access information about complementary practices and use those techniques with patients.

I sought information about nutritional supplements and spent hours reading labels in health food stores trying to intuit what something was good for. I resented rules that make that information hard to obtain. I am afraid when I hear demands from some to protect the public by banning or controlling all herbal substances. The prescription drugs that are the alternative are advertised with the side effects that often sound worse than the symptom being treated.

Objective research should be conducted on the effectiveness of nutritional supplements and other products and practices. I have heard research workers tell how the results of studies by drug manufacturers are suppressed if they don't have an outcome in the financial interest of the company that funded the research. This reminds me of the cigarette scandals where knowledge of health risks were hidden from the public for decades. I would support tax dollars to conduct research.

The new Minnesota law provides the protections that I need as a consumer. I am pleased that there are not standards for licensure as many of the modalities are best taught person to person rather than in a structured class. I note that the law passed in Minnesota without much opposition in the final form.

It is important the allopathic and the complementary healing arts not be competitive. There is a need for both. There never is an excess of good health. Information to the consumer is needed so they can make informed choices about the health care received by their families

Public Comment/Testimony from Jeanne Hollingsworth to the White House Commission on Complementary and Alternative Medicine. March 13, 2001

As a consumer and a natural healthcare bodyworker I strongly believe that all people have the right to go to the natural healthcare practioner of their choice regardless of that practitioner's academic training. I believe people have the right to full access to all natural healthcare modalities so that they may choose those which best facilitate their healing process.

I believe my healthcare is my own personal choice and responsibility. It is one of the most personal choices I make.

From my own experience I know that a person with a lot of academic training may not be the most appropriate one to assist with certain health issues. I have found that someone with a natural gift for healing or who has studied with a mentor can be far more effective in my healing process than a person with only academic training.

In my 19 years of experience with natural healthcare I have found that it produces good results in a safe and non-invasive manner. I do not need any protection from it.

I fully support Minnesota Statute 146A, The Complementary and Alternative Health Care Freedom of Access Bill because this is a good solution to the concerns of consumers and practitioners alike. It requires that all practioners disclose their education and training along with information about the modalities and care that they give. This helps people make well-informed choices regarding their heathcare.

This bill provides consumers freedom of access to all healthcare practitioners while holding those practitioners accountable to the MN Department of Health. Appropriate consumer protection and healthcare access are provided simultaneously.This bill is exactly what we need and is an excellent model for the needs of the expanding natural healthcare industry.

Thank you for your time and attention regarding this important matter.

3 minute testimony for Nancy Hone at the President's Commission on Complementary and Alternative Medicine March 16, 20001 in Minneapolis, Minnesota at the Humphrey Institute on the University of Minnesota Campus. #75
I AM SURE YOU ARE ALL GLAD TO SEE ME. NOT FOR WHAT I HAVE TO SAY, BUT BECAUSE I AM THE LAST ONE TO SPEAK AND YOU CAN ALL GO HOME AND EAT WHEN I AM FINISHED.

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

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

****

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

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

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

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

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

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

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

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

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

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

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

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

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

The health boards must be made accountable to the public.

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

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

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

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

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

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

FINAL REMARKS:

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

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

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

My name is Rolf Canton. I have been a massage therapist for sixteen years. My specialty is deep muscle massage therapy. I graduated from the Minneapolis School of Massage and Bodywork in 1987. I completed the 600 hour comprehensive program. Other education includes a Bachelor of Arts degree in Theatre Arts and Humanities from the University of Minnesota in 1969. I completed a one-year, correspondence study in Phytotherapy through a school in Suquamish Washington so I am Certified in Herbal Studies. I also attended law school and film school but completed no degrees. I have a Master of Science degree from Notre Dame de Lafayette University, all done through correspondence.

Complimentary medicine (or alternative health therapies), of which massage therapy is a part, is a safe and less expensive treatment of disease and injury than allopathic medicine, which depends too heavily on treating the body's ills with chemistry. All drugs have side effects, which harm the liver and kidneys in particular. The PDR (Physicians Desk Reference) lists fatigue, nausea and dizziness as common side effects to most drug therapies.

Naturopathy is now the umbrella term encompassing herbal medicine, folk medicine, homeopathy, specialized diets such as vegetarian living, exercise, body alignment such as that which is done by chiropractors and other modes of treatment including the Oriental health philosophies. Naturopathy has a long history in Europe and in the United States. The American Medical Association was organized (1847) after and in reaction to the formation of the homeopathy association formed around 1843. The AMA actually did almost nothing until around 1900 when George Simmons became its president until around 1924-25 when Morris Fishbein became president until 1949. Both men were of dubious backgrounds whose careers ended in scandal. It is interesting to note that there is a statue of Samuel Hahnemann, the father of homeopathy, in Washington, DC., while there is no statue of Fishbein or Simmons anywhere.

It is thought that regulation of things is a good thing and that all regulation should come from the highest level of authority in the land, namely from Washington, DC. It has been thought for several years that licensure is a good thing in order to give distinction to a profession as well as protection to the public from unscrupulous or poorly trained health practitioners. We now realize that licensure is not really applicable to the practitioners of complimentary medicine. Why is that? Alternative health practitioners do not "do harm," which is part of the Hippocratic oath that doctors have sworn to uphold for many, many centuries. However, allopathic practitioners who perform surgery and prescribe synthetic pharmaceuticals to treat all illnesses do indeed need to be monitored by a board of professional responsibility because the potential for harm is significant.

Practitioners of complimentary health do not need such monitoring nor do they need licensure. There should be a free and open market place similar to the Nineteenth Century in the United States and Europe where the practitioner is individually liable to his client/patient for his actions but the consumer has many options available. It is interesting to note that the Rockefeller family invested in allopathic education and treatment yet the family was treated by homeopaths as the English Royal family is still.

Rolf D Canton 3-16-2009
Submitted Written Comments Only

My name is Rolf Canton. I have been a massage therapist for sixteen years. My specialty is deep muscle massage therapy. I graduated from the Minneapolis School of Massage and Bodywork in 1987. I completed the 600 hour comprehensive program. Other education includes a Bachelor of Arts degree in Theatre Arts and Humanities from the University of Minnesota in 1969. I completed a one-year, correspondence study in Phytotherapy through a school in Suquamish Washington so I am Certified in Herbal Studies. I also attended law school and film school but completed no degrees. I have a Master of Science degree from Notre Dame de Lafayette University, all done through correspondence.

Complimentary medicine (or alternative health therapies), of which massage therapy is a part, is a safe and less expensive treatment of disease and injury than allopathic medicine, which depends too heavily on treating the body's ills with chemistry. All drugs have side effects, which harm the liver and kidneys in particular. The PDR (Physicians Desk Reference) lists fatigue, nausea and dizziness as common side effects to most drug therapies.

Naturopathy is now the umbrella term encompassing herbal medicine, folk medicine, homeopathy, specialized diets such as vegetarian living, exercise, body alignment such as that which is done by chiropractors and other modes of treatment including the Oriental health philosophies. Naturopathy has a long history in Europe and in the United States. The American Medical Association was organized (1847) after and in reaction to the formation of the homeopathy association formed around 1843. The AMA actually did almost nothing until around 1900 when George Simmons became its president until around 1924-25 when Morris Fishbein became president until 1949. Both men were of dubious backgrounds whose careers ended in scandal. It is interesting to note that there is a statue of Samuel Hahnemann, the father of homeopathy, in Washington, DC., while there is no statue of Fishbein or Simmons anywhere.

It is thought that regulation of things is a good thing and that all regulation should come from the highest level of authority in the land, namely from Washington, DC. It has been thought for several years that licensure is a good thing in order to give distinction to a profession as well as protection to the public from unscrupulous or poorly trained health practitioners. We now realize that licensure is not really applicable to the practitioners of complimentary medicine. Why is that? Alternative health practitioners do not "do harm," which is part of the Hippocratic oath that doctors have sworn to uphold for many, many centuries. However, allopathic practitioners who perform surgery and prescribe synthetic pharmaceuticals to treat all illnesses do indeed need to be monitored by a board of professional responsibility because the potential for harm is significant.

Practitioners of complimentary health do not need such monitoring nor do they need licensure. There should be a free and open market place similar to the Nineteenth Century in the United States and Europe where the practitioner is individually liable to his client/patient for his actions but the consumer has many options available. It is interesting to note that the Rockefeller family invested in allopathic education and treatment yet the family was treated by homeopaths as the English Royal family is still.

Rolf J Canton 3-16-2008

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. email	Gisela DiCarlo to WHCCAMP re Comments to the Commission (partial) (1 page)	02/27/2001	b(6)

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

OA/Box Number: 43231

FOLDER TITLE:
WHCCAM Town Hall Meeting Testimony, Minneapolis, Minnesota, March 16, 2001
[Folder 1] [5]

2011-0568-S
kc803

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

[002]

Albrecht, Joan (NCCAM)

From: just4me@pikeonline.net
Sent: Tuesday, February 27, 2001 5:35 PM
To: Whccamp (NCCAM)
Subject: Comments for the Commission

First Name: Gisela
Middle Initial:
Last Name: Di Carlo
Address: (b)(6)
Address2:
City: Milford
State: PA
Zip: 18337
E-mail: just4me@pikeonline.net
Comment:
Dear members of the Commision!
I am currently enrolled at the Clayton School for natural Health in the Naturopath Doctorate program. I like to urge the commission to leave the path open for distand learning in the alternative health practises. I am a licensed Esthetician and Massage Therapist and must work to earn a living, I cannot afford to go to a school in another state for 4 years - licensing ND's who graduated from only the 3 Colleges currently (Bastyr,Arizona,Conneticut)is a real hardship for people who are not wealthy enough to afford to go to these schools.Distand learning was definately an answer for me as it is for other people. Besides distriminating against other schools (if they do not offer the needed curiculum - then make one standard curriculum and let any one who is interested and able to pass the admission study either by distand or in attendance) Distance learning is definately becomming the answer for many Universities today,(Columbia etc all have started a distand learning program) !
most subjects can be studied this way and if there is a need for visual, admitt videos to the learning mix. MD'S are flocking to the natural health learning centers, to learn the needed modaligys that the medical schools are omitting. They are learning by dtand learning system. Because the public obviously needs and wants gentler and more natural 'cures'. Allopathy and natural healers should join hands and start helping people. Your commission should remember that before the strangle hold of the AMA who joined hands with the pharmaceutical companies to make the big bucks - there where Homeopathic Doctors, Naturopath and Herbology Doctors who helped people thrue many plagues with considerable success. We DO NOT NEED MORE LICENSING - WE RATHER NEED TO UNDERSTAND THAT HEALING AND HELPING CAN BE DONE BY MANY AND SHOULD NOT BE DOLED OUT TO A FEW WHO ARE WEALTHY TO GO TO THE RIGHT SCHOOLS. Just think if only the Law degrees of Harvard and Yale would be admissable to court. What a !
disaster that would be. :) Please do not fall into the litany of the AMA that only Doctors from medical schools hold the keys to the holy gral of medicine, if any of you are interrested they should read the charter of the AMA - They pledged to eradicate any Homeopathic Doctor to form a monopoly for the MD's and the AMA. What a disservice to health and wellness for all people. Natural health practitioners are for the most part educators, they teach ther clients how to PREVENT illness and that should be in the intrest of all of us especially with the rising cost of health care and the many 'half healthy' people in our country. So please make a standard for natural health pratitioners - but allow students to study in the fashion that is best for each. And do not just license a few, thousands have gone thrue the CLayton School for their ND - and I know many have flourishing practises for wellness education, some have written books and educated that way. Please do not deprive ! the public of this service.We need to continue to be able to teach peple

how to stay well and I for one 'am doing just that in my health spa. We do not want to practise medicine and prescribe medicines. The ND'S that are turned out of the above mentioned schools are a new and different kind of Doctor - they are not MD's and they are not Naturopath in the strictest sense, just another medical degree that is designed to confuse the public. Thank for your attention.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. email	Kay Eldrid to Senator Tom Harkin et al re Protocol Info (4 pages)	02/28/2001	b(6)

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

OA/Box Number: 43231

FOLDER TITLE:
WHCCAM Town Hall Meeting Testimony, Minneapolis, Minnesota, March 16, 2001
[Folder 1] [5]

2011-0568-S
kc803

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. email	Kay Eldrid to Senator Tom Harkin et al re Montel Williams Letter (2 pages)	02/28/2001	b(6)

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

OA/Box Number: 43231

FOLDER TITLE:
WHCCAM Town Hall Meeting Testimony, Minneapolis, Minnesota, March 16, 2001
[Folder 1] [5]

2011-0568-S
kc803

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Albrecht, Joan (NCCAM)

OK given to Michelle 3/28/01

From: LCald29358@aol.com
Sent: Monday, March 26, 2001 6:00 PM
To: Albrecht, Joan (NCCAM)
Subject: Re: March 16 Town Hall Meeting

James S. Gordon, M.D. Stephen C. Groft, PharmD

Dear Mr. Gordon,

I am pleased that you gave our community the opportunity to present a synopsis of our views. You may feel free to call upon us for further details
at your convienence. We will continue to support the flow of information in
order to reduce misunderstandings.

Again, Thank you for your time and efforts on behalf of the American Public.

Larry P. Caldwell, D.O.M., L.Ac.
President of the Acupuncture Association of Minnesota

Jan,
For your consideration
for the Report
Thanks

Whccamp (NCCAM)

From: Jan Forsberg [info@homeopathicschool.org]
Sent: Thursday, March 15, 2001 11:26 PM
To: Whccamp (NCCAM)
Subject: MINNESOTA MODEL FOR HEALTH FREEDOM

March 15, 2001

To: White House Commission on Alternative and Complementary Medicine
From: The Northwestern Academy of Homeopathy

The Northwestern Academy of Homeopathy was founded in 1995 as a training institution for classical homeopathic practitioners. Our four-year program offers a total of 1,440 hours including 610 hours of extensive clinical training. Our standards meet, and in some areas, exceed, the 1993 guidelines for training published by the International Council on Classical Homeopathy.

We wanted to let you know that we are strong advocates of the Minnesota Model. We acknowledge that government regulation is important to protect the safety of its citizens but that the health care consumer's right to choose is equally important. In our experience, government officials do not have the necessary expertise to set appropriate standards in the areas and hours of training for the numerous safe and effective complementary healing modalities that exist in today's health care marketplace. We have seen that in an open market, with full support for the consumer to make an informed choice, the most effective and competent practitioners will be found and will flourish.

We applaud the Minnesota Legislature for following a fundamentally sound principle: "that no regulation shall be imposed upon any occupation unless required for the safety and well-being of the citizens of the state." The Minnesota Model ably follows this principle and protects the consumer's right to choose appropriate individual health care while at the same time protecting that consumer from fraud or harm.

If you have any additional questions about our commitment to the Minnesota Model, please do not hesitate to contact me at 1-877-644-4401..

Sincerely,
Eric Sommermann, R.S. Hom., Ph.D.
Dean