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

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WHITE HOUSE COMMISSION on CAM
TOWN HALL MEETING

MINNEAPOLIS, MINNESOTA, March 16, 2001

Submitted by: Rose Haywood, L.Ac., Dipl.Ac. (NCCAOM)
Academic Dean, Minnesota College of Acupuncture and Oriental Medicine
of Northwestern Health Sciences University.

The Importance of Quality Education in Oriental Medicine

Introduction
Patients have the right to safe and effective health care.
The key to safe and effective healthcare is education.
Professional education of Oriental medicine practitioners is rigorous, comprehensive, and accredited, and exemplifies quality education in CAM.

Definition of terms:
Oriental medicine is a comprehensive system of healthcare, which may include acupuncture, herbs and oriental bodywork.

The theories underlying traditional oriental medicine, including physiology, pathology, diagnosis and treatment strategy and methods, rest on an understanding of natural phenomena that has evolved over two thousand years. These theories are quite different from those of western biomedicine, but entirely logical and pragmatic when considered from within the whole paradigm.

The treatment modalities of OM should be used within the complete framework of OM, or efficacy is compromised. For example, acupuncture is not merely the insertion of needles into so-called "trigger" points (painful spots). The choice of acupuncture points is guided by a complete Oriental medicine diagnosis, which can be performed correctly only by a thoroughly trained practitioner. The choice of a Chinese herbal formula for a particular patient depends on the ability to make a competent traditional diagnosis, a thorough knowledge of the many traditional characteristics of over three hundred herbs in common use, as well as the traditional rules of combination, an in-depth knowledge of the traditional herbal formulae and how to adapt them to the requirements of the individual patient, and contra-indications for their use. It is impossible to practice Chinese herbal medicine safely and effectively outside of the framework of the complete system of oriental medicine.

Regulatory organizations
Standards of competency for the practice of OM are regulated by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) The NCCAOM administers written and practical board examinations in acupuncture, herbology and bodywork, requiring documentation of thorough professional education via apprenticeship or formal education. Formal education consists of graduation from an accredited school.

The Accreditation Commission for Acupuncture and Oriental Medicine is a specialized accrediting agency recognized by the US Dept of Education and the Council on Higher Education Accreditation. ACAOM was established in 1982 to set up and assess compliance with educational standards for acupuncture and OM programs in the U.S.
In order to receive and maintain accreditation, schools must constantly assess and improve their programs.

The Masters of Acupuncture and the Master's of Oriental Medicine accredited by ACAOM

The accredited Master's level acupuncture curriculum is 3 academic years (minimum 1725 hours) with 705 hours in Oriental medical theory diagnosis and treatment techniques and 660 hours of clinical training.

The accredited Master's degree in Oriental medicine (i.e. including herbology) is four academic years (2175 hours) with 705 hours in Oriental medical theory diagnosis and treatment techniques, 450 hours in Oriental herbal studies, 660 hours of clinical training.

These are minimum guidelines. In reality, most programs are considerably longer.
Our college's program is typical, at 2800 hours for OM and 2350 for Acupuncture.

Why should the training program be this long?

The simple answer is: to ensure safe and effective practice.
Graduates of ACAOM-accredited institutions receive a thorough training in the OM theory, diagnosis and treatment, clinical practice and sufficient hours in biomedical clinical sciences to enable them to recognize serious conditions and conditions that require referral to a western physician. The program lengths are those deemed necessary to produce graduates who can practice safely and effectively.

The problems that we face

Oriental medicine is an extremely safe system when practiced by properly trained individuals. Unfortunately, the treatment modalities of oriental medicine are being taken out of the larger theoretical and philosophical context and practiced by other professionals with minimal training.
Acupuncture is known to be a highly effective treatment modality. It is therefore being adopted as a tool by other types of provider. Without the knowledge of the complex theoretical background of the medicine, however, and without the rigorous and comprehensive training necessary to gain this knowledge, what is being practiced becomes a mere mechanical procedure, which bears little resemblance to acupuncture as practiced by professional practitioners who understand the whole system.

The results of this co-optation of oriental medicine are, first, that efficacy and patient safety are compromised. (Please refer to the appended: Safety Record of Acupuncture)
Chinese herbal medicine, indeed, herbal medicine in general, is being practiced by a variety of practitioners with minimal training. The potential consequences of practicing herbal medicine without proper training are serious.
One of the subtler but no less destructive outcomes of this type of low-level practice of oriental medicine, is the deception of the general public, who are generally unaware of the differences in the level of education between professional oriental medicine practitioners and those who have taken short courses. The patient who visits a minimally-trained practitioner may, at the worst, be harmed, at best, helped somewhat, but very frequently, does not see results from the treatment, and then blames the medicine rather than the practitioner. This harms our profession.

Our desires as a profession

We wish to work in harmony with biomedical providers, in a professional atmosphere of mutual respect, where the skills of each type of practitioner can be best utilized.
We wish to have our medicine respected as a comprehensive system, not misunderstood, devalued, co-opted by other providers who do not recognize the necessity for rigorous educational standards in oriental medicine.
Practitioners in the few states that require referral from an M.D wish to have the freedom to practice without the requirement of referral.
In fact, three states' medical boards have recommended dropping the referral requirement.

Recommendations

1. Public education: The public needs better information on educational standards for the practice of acupuncture and herbology, in order to make better informed choices of practitioner.
2. Access: members of the public should be able to consult an OM practitioner of their choice without a referral.
3. The practice of OM is safe and effective and much cheaper than western biomedicine. It should be reimbursed by insurance providers.
4. The educational standards for the practice of acupuncture and Chinese herbal medicine as set up by ACAOM should be the standards adopted for the practice of Oriental medicine by all providers. Educational programs in acupuncture and chinese herbology offered by medical schools, naturopathic colleges and colleges of chiropractic should be held to ACAOM standards.

Acupuncture and Oriental Medicine Alliance

Legislative Update

May 5, 2000

Jurisdictions With Acupuncture Laws

Alaska	Arizona	Arkansas
California (own exam)	Colorado	Connecticut
District of Columbia	Florida	Georgia New 2000
Hawaii	Idaho	Illinois
Indiana	Iowa	Louisiana (no exam)
Maine	Maryland	Massachusetts
Minnesota	Missouri	Montana
Nevada (own exam)	New Hampshire	New Jersey
New Mexico	New York	North Carolina
Ohio New 2000	Oregon	Pennsylvania
Rhode Island	South Carolina	Tennessee New 2000
Texas	Utah	Vermont
Virginia	Washington	West Virginia
	Wisconsin	

States That Allow Practice Through a Ruling by the Board of Medical Examiners

Kansas Michigan

States in Which There is No Legislation or Rule

Alabama*	Delaware	Kentucky*
Mississippi	Nebraska* the passed bill on Gov's desk	North Dakota
Oklahoma*	South Dakota	Wyoming*

*A statute has been introduced

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For a current list, see our web page at *www.AcupunctureAlliance.org*

NATIONAL ACUPUNCTURE FOUNDATION

EDUCATION AND RESEARCH IN ACUPUNCTURE, ORIENTAL HERBS, AND OTHER ASPECTS OF ORIENTAL MEDICINE
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January 1, 2000

Safety Record of Acupuncture

Due to the growing demand for acupuncture services, regulators throughout the United States are faced with setting standards to protect the public. One of the first questions which surfaces in discussing legislation is the risk of harm involved in acupuncture.

The evidence shows that, when performed by trained individuals, acupuncture is an extremely safe procedure and has a remarkably low record of accidents.

In 1983 - 84, recognizing that it was essential to set standards of competence, the acupuncture profession in the United States established the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). One of the primary reasons for setting national standards was - and is - to protect the public from unqualified practitioners.

Potential harm to the public falls into two primary categories, the risk of accidental injury to internal organs and complications due to improper sterilization and clean needle technique, including the possible spread of infectious disease.

The attached chart, *Safety Record of Acupuncture,* reflects reports in the medical literature in English since 1958 from the United States, West Germany, England, Israel, Ireland, Australia, Japan, China, Spain, Belgium and Switzerland. Three additional articles in foreign languages cited in the English literature are also included, one each from Belgium, West Germany and Japan.

The chart shows a remarkable safety record for acupuncture throughout the world. This is particularly true considering that in three of the countries listed, China, Korea and Japan, acupuncture is a frequent form of health care for hundreds of thousands of people.

Regarding the risk of injury to internal organs, the first risk, acupuncturists are trained in exact needle placement, angle and insertion depth. This results in an extremely low risk of injury when acupuncture is performed by a competent individual. This is demonstrated by the following:

- In China and Japan, both of which have excellent training programs for acupuncturists and thousands of treatments annually, only ten injuries to internal organs have been reported since 1972.
- No injuries have been reported from Korea.
- In the United States, only ten incidents of injury have been reported since 1965.

- Of the ten cases in the United States, one was noted as a "one-in-a-million" complication, another as a bizarre set of circumstances involving self-inflicted injury by an untrained individual.
- Of the reports from the United States, only one specified that the treatment had been performed by a licensed or certified acupuncturist and that individual was licensed without examination or standards of competency.
- In the reports from the other Western countries, in most of which only M.D.s may practice acupuncture, it was unclear who had performed the treatment.
- In the fourteen years that the NCCAOM has certified over 9000 individuals in acupuncture, NCCAOM has never had reason to take action against a Diplomate due to negligent or harmful treatment to a patient.

Additionally, in the cases in which there was damage to internal organs, in most cases, except the two unusual cases noted above, the patient recovered and the damage was minimal. In fact, in the cases of retained or broken needle, the needle had been in place up to 35 years without complications.

From the outset, the acupuncture profession in the United States recognized the second risk of harm to the public, the risk inherent in the use of unsterile needles and lack of clean needle technique. Thus, one of the first tasks of the profession was to establish standards for clean needle technique (CNT). Therefore, in concert with the Center for Disease Control in Atlanta, Georgia, the profession developed the Clean Needle Technique Manual, published by the National Acupuncture Foundation. The CNT Manual serves as the basis for questions on the NCCAOM written examination as well as for the national CNT Course offered by the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM). Passage of the CNT Course is required for NCCAOM certification and for licensure in most states.

The chart demonstrates that complications due to improper clean needle technique occur in countries, states or professions which have not set standards of clean needle technique for acupuncture practice. Additionally, of the seven complications due to improper clean needle technique in the United States, only three were due to treatment by acupuncturists. One individual was not licensed or certified, one was licensed without exam and the status and background of the third was not mentioned. No such incident to date has been reported involving a nationally certified acupuncturist who has met national CNT requirements.

In the entire literature search, only four fatalities were reported. Three of these involved patients with significant health problems which the authors stated contributed to the death. The fourth involved self-treatment for a heart condition.

The second chart, *Safety Record of Certified, Licensed or Registered Acupuncturists,* reemphasizes the safety of acupuncture when performed by trained individuals. This chart shows the responses received from a survey of twenty state licensing boards regarding injuries due to acupuncture which had been reported to them. Of the 20 states surveyed, only two states reported any injuries due to acupuncture. Again, this is a remarkable record. Several of the states have permitted practice for over ten years and have over one hundred licensed acupuncturists

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The evidence clearly shows that acupuncture is extremely safe when performed by well-trained individuals who have met solid standards of practice. Thus, the only significant danger to the public lies in lack of standards and in performance of acupuncture by improperly or poorly trained individuals. For this reason, regulations establishing standards of competence are essential to protect the public.

NATIONAL ACUPUNCTURE FOUNDATION
January 1, 2000

SAFETY RECORD OF ACUPUNCTURE

Complication	Author/Year	Practitioner	Note
Complications Due To Injury to Internal Organs -			
Pneumothorax	Schneider & Salzberg Annals of Emergency Medicine 13: 8 (1984)	M.D.	- full recovery - acupuncture licensure (New York) - standards for M.D.s
	Bodner et al Annals of Allergy 51: 401 (1983)	1 non-M.D. 1 not specified	- full recovery in both cases - no set standards (Israel)
	Valenta & Hengesh Lancet 2: 322 (1980)	not specified	- full recovery - acupuncture licensure (California) - no standards for other health professionals
	Goldberg Medical Journal of Australia 1: 941 (1973)	not specified	- full recovery without treatment - no set standards (Australia)
	Stack British Medical Journal 1: 96 (1975)	not specified	- full recovery without treatment - no set standards (England)
	Ritter & Tarala British Medical Journal 2: 602 (1978)	3 cases non-M.D.	- full recovery in all three cases, one without treatment - no set standards (England)
	Mazel et al New England Journal of Medicine 302: 1365 (1980)	not specified	- recovery after hospitalization - acupuncture licensure (New York) - standards for M.D.s
	Corbett & Sinclair New England Journal of Medicine 290: 167 (1974)	not specified	- complete recovery after treatment - no set standards (California 1974) - no standards for other health professionals
	Waldman New England Journal of Medicine 290: 633 (1974)	not specified	- complete recovery after treatment - no set standards (Florida 1974)
	Lewis-Driver Medical Journal of Australia 2: 296 (1973)	non-M.D.	- complete recovery - no set standards (Australia)
	Smith & Rauscher Journal of the American Medical Association 229: 1286 (1974)	not specified	- fatal; pneumothorax resolved but patient reserves minimal due to severe pulmonary emphysema and patient died - said was "one-in-a-million" complication - no set standards (Arizona)
	Kuiper Journal of the American Medical Association 229: 1422 (1974)	not specified	- full recovery - no set standards (California 1974)

NATIONAL ACUPUNCTURE FOUNDATION
January 1, 2000

SAFETY RECORD OF ACUPUNCTURE

Complication	Author/Year	Practitioner	Note
Cardiac Tamponade	Nicda & Kuribayashi Japanese Journal of Thorasic Surgery 26: 881 (1973)	not specified	- surgery; uneventful post operative recovery - retained needle (Japan)
Compartment Syndrome	Smith et al Western Journal of Medicine 144: 478 (1986)	physician trained in acupuncture	- full recovery - no standards for physicians (Oregon) - noted necessity to weigh possibility of intercompartmental hemorrhage on patients receiving anticoagulation therapy vs. benefits of acupuncture
Renal Complications	Keller Journal of the American Medical Association 222: 1559 (1972)	not specified	- asymptomatic for 35 years, removed without problem - retained needle (China)
	Drake Journal of the American Medical Association 229: 1285 (1974)	not specified	- asymptomatic for "many years"; removed without difficulty - retained needle (China)
	Shiff Medical Times 93: 630 (1965)	non-M.D. self-inflicted	- fatal; authors noted bizarre circumstances of self-inflicted injury - no set standards (Florida 1965)
Spinal Cord Root Injuries	Toyohiko et al Surgical Neurology 23: 255 (1985)	3 cases not specified	- full recovery in 2/3 cases post-op; one case not operated - numb fingers only - authors note rarity of spinal cord injury by acupuncture (Japan)
	Kataoka & Sakata Geka 20: 578 (1958)	unknown	- unknown
	Kondo et al Surgical Neurology 11:155 (1979)	not specified	- minor sensory impairment after surgery - retained needle (Japan)
	Shiraishi & Gota Neurology 29: 1188 (1979)	acupuncturist (unknown if licensed)	- minor sensory impairment after surgery - retained needle technique (Japan)
	Kida et al Archives of Neurology 45: 831 (1988)	not specified	- minor sensory impairment after surgery - authors note rarity of occurrence given thousands of treatments and long history of acupuncture in Japan
	Isa & Sasaki, et al Surgical Neurology 23: 255 (1985)	2 cases not specified	- uneventful post operative course; slight loss of pain and temperature sensation remaining after surgery - retained needle (Japan)
Miscellaneous	Campbell British Journal of Radiology 55: 875 (1982)	acupuncturists (unknown if licensed or certified)	- persistent backache; no treatment undertaken - retained needle technique - seaman who had visited acupuncture practitioners around the world

NATIONAL ACUPUNCTURE FOUNDATION
January 1, 2000

SAFETY RECORD OF ACUPUNCTURE

Complication	Author/Year	Practitioner	Note
Complications Due to Improper Clean Needle Technique or Improper Sterilization	Stryker et al Journal of Family Practice 22: 155 (1986)	D.C.	- all recovered - no set standards (Florida chiropractors)
Hepatitis B	Kobler et al Schweiz Med Wochenschr 109: 1828 (1979)	physician 3 cases	- no set standards (Switzerland)
	de Galocsy Acta Gastroenterol 45: 224 (1982)	unknown 6 cases	- no set standards (Belgium)
	Li & Shiang Journal of the American Medical Association 243: 1423 (1980)	none	- not a case report - letter re potential infection in China
	Boxal Journal of Medical Virology 2: 377 (1978)	non-M.D.	- all recovered - no set standards (England)
	Alexander et al British Medical Journal 2: 466 (1974)	none	- not a case report - letter re potential infection in China
	Hussain British Medical Journal 3: 41 (1974)	not specified	- author noted other possible causes - no set standards (England)
	Kent et al American Journal of Epidemiology 127: 591 (1988)	35 cases acupuncturist (licensed without examination)	- regulated jurisdiction (RI) but acupuncturist licensed without examination or clean needle technique standards and did not use acceptable CNT procedures
HIV	Vittecoq et al New England Journal of Medicine 320: 4 (1989)	unknown	- only M.D.s may perform acupuncture in France but there are no set standards of training - AIDS symptoms appeared 4 months after initial acupuncture treatment - too short a time for acupuncture to have been the cause of infec
Septicaemia	Pierik Rhode Island Medical Journal 65: 251 (1982)	2 cases not specified	- fatal - other significant health factors noted - acupuncture licensure (Rhode Island)
Subacute Bacterial Endocarditis	Lee & McIlwain International Journal of Cardiology 7: 62 (1985)	non-M.D.	- full recovery after hospitalization - no set standards (England)
	Jefferys et al British Medical Journal 287: 326 (1983)	not specified	- full and uneventful recovery - no set standards (England)

NATIONAL ACUPUNCTURE FOUNDATION
January 1, 2000

SAFETY RECORD OF ACUPUNCTURE

Complication	Author/Year	Practitioner	Note
Petechiae	Bushta American Journal of Diseases of Children 123: 613 (1972)	acupuncturist	- no set standards (California 1972)
Auricular Chondritis or Perichondritis	Davis & Powell Arch Otolaryngol 111: 770 (1985)	not specified	- minimal deformity - no set standards (Illinois)
	Allison & Kravitz New England Journal of Medicine 293: 780 (1975)	not specified	- acceptable appearance after 2 weeks of treatment - no set standards (California 1975)
	Jones Journal of Laryngology and Otology 99: 1143 (1985)	4 cases not specified	- complete recovery without deformity - no set standards (Ireland)
	Baltimore & Moloy Archives of Otolaryngology 102: 572 (1976)	acupuncturist (unknown if licensed or certified)	- complete recovery without scarring - acupuncture licensure (Massachusetts)
	Trautermann H.N.O. 29: 312 (1981)	Heilpraktiker (similar to naturopath)	- no set standards (West Germany)
Osteomyletis	Jones & Cross Journal American Podiatry Association 70: 149 (1980)	not specified	- slight scar after antibiotics and surgery; no further symptoms - regulated jurisdiction (Korea) but no clean needle technique standards and little enforcement of licensing
Spinal Infection Mimicking Prolapsed Disc	Hadden et al Journal of Bone & Joint Surgery 64: 624 (1982)	D.O.	- uneventful post-op course; painfree 9 months later except when lifting very heavy weights - no set standards (U.K.)
Miscellaneous **Contact Dermatitis due to Allergy to Nickel in Acupuncture Needles**	Romaguera et al Contact Dermatitis 7: 156 (1981)	referred to as "the doctor"	- patient allergic to neomycin & nickel in permanent needle; cleared when both discontinued - no set standards (Spain)
	Romaguera & Grimalt Contact Dermatitis 5: 195 (1979)	not specified	- resolved in 18 days with conventional treatment and discontinuance of the acupuncture
	Fisher, Alexander CUTIS 50: 226 (1992)	acupuncturist (unknown if licensed or certified)	- regulated jurisdiction (NY) - author noted no problem with prior acupuncture treatments; assumed different needle composition
Complications with Cardiac Pacers	Fujiwara Chest 78: 96 (1980)	M.D.	- observations during surgery with acupuncture analgesia due to cardiac condition

NATIONAL ACUPUNCTURE FOUNDATION
January 1, 2000

SAFETY RECORD OF LICENSED, CERTIFIED OR REGISTERED ACUPUNCTURISTS

Complaints and Disciplinary Actions Between July 1992 and May 1999

State	Injuries From Acupuncture	Injuries From Herbs	Injuries Due to Use of Acupuncture Instead of Medical Treatment	Other	Complaints & Disciplinary Actions
Alaska	0	0	0	0	Complaints not public inform'n 0 actions
California	16 complaints negl/incompet (2 with injuries), 2 actions	N/A	0	16 complaints sexual misconduct, 6 actions; 76 unprof conduct, 38 actions; 24 complaints unlicensed practice; 41 other, 5 actions	173 complaints 51 actions
Colorado	1 complaint	0	0	4 sexual harassment (one person), 1 action; 2 CNT complaints, 1 action; 9 unlicensed/beyond scope, 4 actions	16 complaints 6 actions
Hawaii				2 complaints of unlicensed practice; 10 other	12 complaints
Maine	1 complaint	0	0	1 complaint unethical practice	2 complaints 0 actions
Maryland	1 complaint, 1 revocation	0	0	1 complaint of sexual harassment, 3 of unethical practice (advisory letter issued)	5 complaints 2 actions
Massachusetts	0	0	0	2 complaints sexual harassment, 2 unethical practice; 3 other, 1 action	7 complaints 1 action
Minnesota	0	0	0	2 complaints of sexual harassment, 2 actions	2 complaints 2 actions
Nevada	0	0	0	1 complaint of sexual harassment, no action	1 compliant 0 actions
North Carolina	1 complaint, no action	0	0	1 complaint of unethical practice, 0 actions	1 complaint 0 actions
Oregon	0	Unknown	Unknown	Unknown	Unknown
Pennsylvania	2 complaints of incompetence, 1 of malpractice/negl	0	0	4 complaints outside scope/no referral, a action; 2 abuse/sex misconduct; 11 unlic pract; 13 other	33 complaints 3 actions
Rhode Island	2 complaints	0	0	0	2 complaints 0 actions
South Carolina	0	0	0	1 complaint of sexual harassment, 1 action; 5 other	6 complaints 1 action
Utah	N/A	N/A	N/A	N/A	N/A
Virginia	0	0	0	5+ complaints re: advertising, unlicensed practice (1 person)	5+ complaints 0 actions
West Virginia	0	0	0	0	0

Based on a survey by the National Acupuncture Foundation May 20, 1999

NATIONAL ACUPUNCTURE FOUNDATION
January 1, 2000

SAFETY RECORD OF LICENSED, CERTIFIED OR REGISTERED ACUPUNCTURISTS

Safety Record Survey July 1992

State	Licensure for Acupuncturists	Number of Acupuncturists	Number of Injuries Caused by Acupuncturists	Number of Injuries Attributed to Use of Acupuncture Instead of Medical Treatment
Alaska	2 years	7	0	0
Arizona	no licensing	3 Physician's Assistants	0	0
California	16 years	3700	unknown	unknown number
Colorado	2.5 years	99	0	unknown
Delaware	not licensed but permitted to practice under MD supervision for 6 years	Unknown	0	0
District of Columbia	6 years	42	0	0
Hawaii	18 years	252	9 complaints - 6 of misconduct or unethical practice, 2 of incompetence	unknown
Louisiana	17 years	0 at this time	0	0
Maine	4 years	38	0	0
Massachusetts	19 years	356	0	0
Michigan	none	Unknown	0	0
Minnesota	none	Unknown	2	0
New Jersey	9.5 years	45	0	0
New Mexico	14 years	236	0	0
New York	16 years	270	0	0
Rhode Island	12 years	23	0	0
South Carolina	18 years	3	0	0
Utah	9 years	20	0	0
Washington	7 years	136	0	0
Wisconsin	2 years	75	0	0

Based on a survey of state licensing agencies by Ralph Nesson, R.Ac. and Ralph Coan, M.D., July 1992

Michael Green

The White House Commission on Complementary and Alternative Medicine Policy
Town Hall Meeting: March 16, 2001
Humphrey Institute, Cowles Auditorium, Minneapolis, Minnesota

The Honorable James S. Gordon, MD
Commissioner George DeVries
Commissioner Wayne Jonas
Commissioner Linnea Larson
Commissioner Joseph Pizzorno

Thank you for allowing me to speak to you and others at this meeting today.

I am a board-certified Family Practice physician in private practice in Minneapolis. For several years now my practice has been limited to the use of various forms of acupuncture, mostly for the treatment of chronic pain, but occasionally for other conditions. The majority of my training has been through the UCLA Acupuncture for Physicians course and I expect to receive board certification from the American Board of Medical Acupuncture (ABMA) in the near future. I also have experience in the education of Licensed Acupuncturists having served in several capacities including that of Academic Dean at the Minnesota College of Acupuncture and Oriental Medicine of Northwestern Health Sciences University.

Reimbursement and the Effect of Coding Standards

In addition to the general problem of lack of reimbursement for CAM evaluation and treatment by both private and public health insurance, existing coverage is complicated by the use of coding systems (ICD-9 and CPT) poorly suited for describing conditions treated and treatments given by nearly all CAM systems. Although many patient presentations can be described by ICD-9 codes, its emphasis is on physician-centric Western diagnoses rather than the patient-centric symptoms and signs found in most CAM systems. Even the section of ICD-9 concerned with "Symptoms, Signs and Ill-defined Conditions" is badly lacking in concepts basic to a variety of CAM systems.

Similarly, the CPT system lists only two codes for acupuncture differentiated only by whether or not electrical stimulation is used. In practice, this is much less important than whether other, more time-consuming or therapeutically important but unlisted therefore unpaid acupuncture treatment modalities are used.

HCFA is in the process of defining new standards for documentation (and the definition) of Evaluation and Management service codes. In most non-Western systems, there is a heavy focus on a patient's history and review of systems and often the physical exam is fairly limited by Western medical standards. The decision making process is also considered limited and is usually of little risk. Because the E&M code is determined by the least intensive of history, examination and decision making, CAM E&M is usually undercoded, therefore under-reimbursed.

I would hope that this commission can recommend that the coding systems used for medical reimbursement and review be revised to better represent the very different paradigms of CAM systems..

Education and Regulation

In the laudable interest of providing high quality care for the public and in the struggle for legitimacy in today's medical system, a whole host of organizations have come into existence to define and control what is legitimate complementary and alternative medical care and training. This ignores what are significant differences in philosophy and therapies among what appear to be very similar groups of practitioners. In the push to regulate or otherwise categorize CAM too quickly, we may end up inhibiting legitimate methodologies or paradigms. In my own area, my training includes a number of techniques that are not based on Oriental medical principles yet look like acupuncture. Most are not taught in acupuncture schools nor are they part of the NCCAOM board exam as far as I know. They are taught in the UCLA program and appear on the ABMA's board exam.

Both the NCCAOM and the ABMA have spent (and continue to spend) considerable resources on developing fair, accurate and comprehensive examinations and other requirements for what they and their related professional organizations believe define their somewhat different knowledge bases and core professional competencies. Less well defined are the fundamental differences in their assumptions about how that knowledge needs to be acquired. I'm sure similar issues divide other CAM professional groups.

I would hope that the commission moves carefully in suggesting paths to the future in this area. Perhaps the Department of Education's experience in accrediting higher education institutions can be of help. In some ways, professional competency standards organizations are not too different from institutions of higher education.

Michael Green, MD

Education of Health Professionals Panel

Testimony of Mary Jo Kreitzer PhD, RN
Director, Center for Spirituality and Healing
University of Minnesota

Honorable Commissioners - Welcome to Minnesota

Over the past several months as the Commission has held hearings, I suspect that you have often heard statistics quoted from the Eisenberg study on the high utilization of complementary and alternative medicine. Today I want to highlight a different study that will provide a context for my remarks and policy recommendations. Dr. Jon Astin in his study that that looked at profiles of people who use CAM therapies found that fewer than 5% of the population seeks access to CAM as an alternative. The remaining 95% are seeking care that draws from the best of healing traditions - both complementary and conventional. This has very significant implications for how we educate health professionals as well as CAM providers.

The University of Minnesota is strongly committed to preparing health professionals who are knowledgeable about CAM and who can help patients evaluate options. We believe that it is critical that nurses, physicians, pharmacists and other health care providers know how to make referrals to CAM providers and to work within an interdisciplinary team that includes providers from many different healing traditions. We recently were awarded an NIH grant to help expand our educational initiatives in this area.

Additionally, there are biomedical providers - physicians, nurses and others - who are returning to school to acquire new skills in CAM because they want to expand their knowledge base and repertoire of skills. Many of these health professionals are keenly aware of the risk of reducing these healing traditions to tools that are provided in a reductionistic way. They also recognize that many of these complementary and alternative systems of care are based on worldviews that are entirely different from the biomedical model in which they were educated. There is a need to educate healers who are capable of practicing in a way that embraces multiple worldviews.

From a policy perspective, there are four recommendations that I urge you to consider:

- To date, schools that are developing programs to educate health professionals in CAM are doing so as a result of demands from students, consumers and at times faculty. Curriculum is often optional and elective. Accreditation requirements and board exams need to be changed so that CAM becomes an integral part of required education.
- Academic Health Centers need funding to develop curriculum for both the basic training of health care providers as well as funding to develop specialized programs to educate health professionals who want to acquire additional skills in CAM. There are only a handful of graduate and fellowship programs in the

country. I serve on the policy board of a Foundation that provides fellowships to physicians seeking mid-career change. Over the past three years, 25-30% of all applicants are seeking training in CAM related areas. There are not enough training programs to prepare physicians in CAM.

- To create a health team that is interdisciplinary and integrated, we also need to address the need for training of CAM providers. Present CAM education programs often do not include information on working with biomedical providers or working within an interdisciplinary team. Federal funding to date has been limited to funding of conventional health professional education programs.
- There are very few clinical sites where students from different healing traditions can learn together. We need to create and fund models where students can observe, learn and work in tandem.

There is a poster that just went up at the University with many sets of eyes clearly reflecting different cultures and races - the poster has the words - "you, me, we - we walk the road together - fight racism". As we advance the vision of a health care system that embraces diverse healing traditions, we need to heal the "isms" that divide us. This is a call for education that unites rather then divides - that helps us to achieve something bigger and better than any of us can achieve alone.

Erin Colleen O'Fallon
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As a fourth year medical student, I have had limited experience with alternative and complementary medicine until this spring of my senior year. At that time I enrolled in the University of Minnesota's elective "Introduction to Alternative and Complementary Medicine".

The course lasts three weeks, and consists of visiting approximately 15 different alternative practitioners, meeting their patients, and observing their practice and/or training.

I took this class with seven other medical students. I believe I speak for all of us when I say this was one of the most powerful and thought provoking courses during our medical training.

We feel that every medical student would benefit from this exposure and training. We agree the course is valuable for a variety of reasons. Although focused on complementary and alternative medicine, it definitely enhanced our perspective on allopathic medicine. By glimpsing the world of allopathic practice from the outside, we more clearly understand the strengths and weaknesses of our chosen field. By considering the alternatives we developed critical thinking skills that applied not only to new and novel ideas, but developed our ability to look more critically at our own practices. Second, we feel our visits with different practitioners allowed us to begin build a meaningful understanding, rapport, and level of collegiality. Last, the course increased our interest and confidence in discussing alternative therapies with our patients. Since we know that many Americans now use a wide variety of healing practices, we think our ability to discuss them candidly and knowledgeably is vitally important.

Our brief exposure to the vast field of CAM served well to show us how much more there is to learn. We felt that continued courses during residency training, and as part of continuing medical education would be invaluable. Continued education is required because the scope of CAM is huge. We also recognize that at different times during our careers we would comprehend and integrate our knowledge of CAM in different ways. Of course as with the field of medicine as a whole, the continued expansion and evolution of knowledge and treatments demands keeping your information refreshed and up to date.

I personally plan to continue to educate myself about CAM and its relationship to allopathic medicine. I sincerely believe that my colleagues at all levels of their training would benefit from opportunities similar to the course I took. I hope the future of medical education holds an increase in understanding of CAM by allopathic practitioners. I also hope that collaborative training, dialogue and respect between our many fields and practitioners will enhance the medical care we can offer in the future.

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

"Education of Health Professionals"

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1. Physicians want to learn about CAM. Few have had formal training in either CAM knowledge or practice. Patients are increasingly using it and asking their doctors for advice. Physician faculty were surveyed in 1995 about their interest in CAM at a large mid-western inner city teaching hospital. [1]90% expressed interest in learning more about CAM. Residents and faculty in the Department of Family Practice were re-surveyed in 2000 and continue to show very strong interest. Physicians stated that they believed that it was their professional responsibility to be knowledgeable regarding CAM.

2. Many patients use CAM in addition to or exclusively for their medical problems. They do not tell their physicians. The efficacy of treatments cannot be fully understood when multiple treatments are being used and not fully discussed. Potentially harmful interaction effects cannot be discerned or responded to. Nor can potentially positive interaction effects be noted and used in practice.

3. Patients, especially minority and refugee patients have used CAM extensively and expect that physicians will be knowledgeable about it. With changing population demographics, knowledge of CAM principles and practices will be increasingly important for physicians.

4. Many people feel that attention to their sacred beliefs is essential to healing. There is deep yearning for relationship and feeling understood, or listened to by their doctors. Many patients want their doctor to pray for them, or with them.

5. CAM values are consonant with primary care values—patient centered, collaborative, comprehensive and wellness oriented.

6. Medical schools are increasingly exposing medical students to alternative healers and CAM principles. [2]Students enter residency eager to learn to integrate their conventional medical training with community needs.

7. Residency trains medical students to become doctors through application and practice. By caring for a panel of patients, they "put it all together". They learn the technical aspects of best practice well with our current system, but few learn to integrate CAM principles or practice into conventional medical care.

8. Little CAM training is offered in residencies across the country. [3]There are few fellowship-training positions. First year resident, Kara Parker MD, said, "I don't want to hold my breath for three years, until I am allowed to put CAM into my practice".

9. Economic pressures to see patients in brief time slots and fear of liability limit physicians willingness to collaborate with community CAM providers and healers. Residency training programs have these same constraints.

10. Time for building relationships and collaboration is not reimbursed. Few professional activities bring CAM practitioners and physicians together.

11. Physicians do not learn to care for themselves. Residency faculty are often poor self-care role models. Adequate rest, exercise, and nutrition is all put on hold while residents are expected to work excessively long hours (average work weeks 80 hours), with "on call" obligations to routinely work 36 hours consecutively. Many Residency Review Committees, (the graduate medical education specialty boards which determine content of residency programs), have adopted mandates for residents to have 24 hours off every 7 days. (The RRC for surgery is an exception to this). Although this is a step in the right direction, it fails to enable residents to care for themselves in any but the most basic ways.

I recently encountered a family physician that trained with me 25 years ago. He values spending time with his patients and knows that they feel better when he simply listens to them. He practices in a small rural college town. He has had a quadruple bypass and knows his job is killing him. He is aging quickly and feeling burned out at 50. He knows that his patterns of self care (or lack thereof) coupled with his compulsive need to respond to people is killing him. He suspects there are answers in the CAM community. Taking a year's sabbatical, he is learning some CAM self care methods. He is deepening his spirituality to try to find ways to be fully present to his patients, and to himself.

12. We do a disservice to our healers with our current methods of training. We encourage idealistic, bright, hard working people to enter medicine and then burn them out with role models who work excessively, within a system that does not remember how to explicitly invite patient beliefs, experiences, practices, relationships, and intuitions into the exam room. The result is wide spread dissatisfaction with the best technical medicine in the world. Our current system does not serve doctors or patients.

Recommendations for policy change and action

National recommendations:

1. That CAM principles be taught in medical schools.
2. That cultural and spiritual assessments, essential in dealing with non majority patients, be taught to all care providers

3. That collaborative community efforts be encouraged so that chronic disease, domestic violence, chemical abuse can be de-medicalized. Patients and communities need to be encouraged to access their own healing skills to help heal themselves.
4. That residency educators convene to find ways to integrate CAM principles and skills into packed curricula.
5. That residency review committees require training in CAM curricula, which includes spirituality, and cultural assessment.
6. That self-care training be included in residency education. Physicians cannot adequately teach people to deal with stress of modern life, unless they can do it for themselves.
7. That physicians collaborate with community healers and CAM providers in caring for patients.
8. That a regional process of certifying competence be established, so that physicians can be relieved of liability worries.
9. That funding is provided for research projects to develop CAM demonstration clinics, to learn which methods are cost effective, and to measure the actual time and resources needed to facilitate collaboration.
10. That health maintenance organizations that develop innovative ways to include CAM in their systems be rewarded. Demand that outcomes measures, quality of care indicators, impact on medical personnel, and economic costs and personnel costs be made public.
11. That competency and knowledge regarding CAM be part of medical board examinations.

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I am honored to be here at this historic event with the wonderful commission members, my esteemed colleagues and the enthusiastic audience. I have been the program director and assistant professor at the College of St. Catherine-Minneapolis in the Holistic Health Studies program for the last eleven of the seventeen years it has been in existence. This professional certification while educating people from a wide variety of professions primarily focuses on the education of health professionals.

Nurses are the largest numbers of any of the health professions enrolled in the program. We have seen nurses who are disillusioned with the growing technological demands on their professions that have made a decision to discontinue conventional nursing. After being in the Holistic Health Studies program they become inspired and charged up to do nursing in a holistic framework.

I collaborated on a unique study conducted in 1999 aimed at the Health Professions faculty in twelve different programs at the College St. Catherine on both the Minneapolis and the St. Paul campuses. 78% of those returning surveys felt that graduating students from health professions need to have knowledge and expertise in the field of holistic and complementary health care to be adequately prepared for the changing demands of the health care market place.

To meet this demand to have health professionals educated in holistic and complementary philosophy, care, research, and practices, I have been part of a team that is in the final planning stages to develop a new Masters program in this field.

The following are important actions and policy recommendations I am bringing forth to the commission in order to impact and change the education of health professionals in the field of holistic, complementary, and alternative health.

- **Action Recommendation**: To enact federal policy and legislation that will make recommendations and mandates to the states which would require the licensing boards of the different health professions to examine and expand their professional practice acts to allow individuals within their professional scope of practice to legally practice and receive reimbursement for using complementary and alternative therapies.

- **Action Recommendation:** To establish a national financial incentive program to encourage academic institutions offering education to health professionals to develop programming and curriculum in the field of holistic and complementary health to

meet the growing demand. We know from the Eisenberg study published in JAMA in November 1998, that almost half the population uses CAM. Our academic institutions that offer health professions degrees need financial incentives to change curriculum to respond to the needs of the public. Academic institutions could apply to this fund for development of departments, programs, and courses in holistic or complementary health care. It could be modeled and structured in a similar way as the system that exists through the National Center for Complementary and Alternative Medicine at the National Institute of Health.

- **Policy Recommendation:** Because the philosophies and theories of some of the holistic health care practices are so different than those of conventional medicine, academic institutions need to root curriculum in the historical and cultural traditions from which many of the practices have evolved. This needs to include partnerships between academic institutions and centers that work to promote the health of cultural communities to guarantee that the voice of cultural ways of knowing are central to the agenda. As a movement that is working towards creating an integrative model of health, it is of utmost importance that we not appropriate or claim as our own, CAM practices that are rooted in cultural traditions

- **Policy Recommendation:** In order for the commission to avoid duplicating the Euro-centric model of health care as we design and envision a different model, it is absolutely necessary that the commission work harder to include cultural healing practices and cultural ways of knowing as central to its agenda and mission.

- **Action Recommendation:** That the commission addresses the serious issues of race and gender bias in medicine practice and research. This will include investigation and research to understand the mammoth scope and extent of this practice and to make recommendations for an action plan.

- **Action Recommendation:** That the commission include a strong emphasis on identifying environmental links to disease and illness and make legislative and policy recommendations to initiative corrective measures. This will include collaborating with current projects and campaigns already underway at the local and national levels aimed at stopping and preventing the continuation of environmental contamination and pollutants, which contributes to disease and illness.

Respecting Belief, Complementary Medicine and IRB policy

Robert Patterson, Ph.D.
University of Minnesota

March 2001

The belief of the practitioner and the patient may be very important for the success of the healing process. Western medicines standard for scientific research studies, the randomized, placebo-controlled, double-blind study, limits or minimizes the influence of belief. In most cases this requires telling the subject that he or she will be receiving the "real treatment" half the time or they have a 50-50 chance of getting the "real thing". This creates doubt in the mind of the patient, which in turn may affect the healing process.

At NIH conference on the placebo last November, many of the studies presented suggested that very real healing occurs from the placebo. I believe most traditional Western scientific researchers, think that the placebo only results in "imagined healing".

As the illustration of this, I would like to present an example of the difficulty I encountered in trying to carry out a qigong study on patients with torticollis treated injections of botulinum toxins every three months to relax the neck muscles. Torticollis is a painful condition in which the neck muscles become continuously active causing the head to be twisted. In our study we wished to have a Qigong master apply a non-touching treatment approximately one week before the patient's scheduled visit for the botulinum toxin injection. We had two outcome measurements. First using an electronic head tracking system, we would very exactly measure the change in head position before and after treatment. The second measure was the opportunity for the patients to cancel their scheduled botulinum toxin injection because it would not be needed due to the relief given by the Qigong practitioner.

The IRB would not approve the study. They required a sham control group. I responded in a letter describing the need to respect the belief process and arguing that since I am carefully measuring the outcome. They again rejected the study for the same reasons.

The following is in part is the written response I received. "We are, however, concerned about the apparent legitimization of a therapy by IRB approval of a study of the therapy, especially when the design of the study is flawed. The combining of IRB approval and a likely positive study outcome, even if the therapy is without effect, misleads both the current subjects and the general public (the latter through news reports, journal reports, and word-of-mouth). Being misleading about the efficacy of therapy is a risk." In my 21 years as a member of the IRB at the University of Minnesota I have never heard this argument being made about any other study before.

I appealed again in person to the panel and executive committee with the same arguments and again I was denied the right to conduct the experiment.

Just two months ago another similarly designed complementary medicine study was submitted to the IRB that I was a member of and the initial response was the same.

Guidance on this issue for IRB panels is given in the Federal OPRR institutional review board guidebook. In section 4 -1, the following question is raised "To what degree is it our responsibility to review the underlying science of the proposed research?" "Clearly, if it is not good science, it is not ethical. The federal regulations under which IRBs operate, however, do not clearly call for IRB review of the scientific validity of the research design." Later in the same document Robert Levine thoughts are given "Levine suggests that IRBs should establish their authority to criticize the scientific merit of protocols and to exercise that authority to require that investigators correct design flaws identified by the IRB before receiving IRB approval, but the IRB's should recognize their limits in this regard as well.

Suggestions for OPRR policies

1. **For minimal risk studies, the IRB shall not require changes in the study design.**
2. **The only risk considered shall be the risk directly affecting the subject.**

I suggest that the Federal OPRR policies be reviewed as they govern IRB procedures. Both complementary medicine and placebo research can be seriously hampered if traditional biases against the merits of these modalities limit the designs that can be used to investigate their efficacy.

White House Commission on Complementary and Alternative Medicine

March 16, 2001

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My clinical background is oncology nursing and my research expertise is CAM intervention research in the fields of cancer nursing and psychoneuroimmunology. I would like to address three components:

1. The need for rigorous, credible research in Complementary and Alternative Medicine to advance the science in the field.
2. Issues and barriers that continue to exist and interfere with conducting well-designed trials that determine efficacy and effectiveness.
3. Recommendations for integrating CAM research into practice and more quickly advancing the science of the field.

Although my written testimony addresses all three components, my talk focuses on recommendations.

I. The need for rigorous, credible research

Regardless of the level of acceptance in mainstream medicine, CAM therapies have infiltrated every aspect of health care.[1] Children with cancer use many different types of complementary and alternative medicine (CAM). Children around the world are using CAM, with 31% to 46% use in children with cancer in the Netherlands,[2] Finland,[3] British Columbia,[4] and Australia.[5] Similar rates are reported in the United States, with 59% use in the Midwest,[6] 65% in Florida,[7] and 84% in New York City.[8] The most common therapies used are prayer and spiritual healing, nutritional supplements, vitamins, massage, and mind-body therapies.[1,4,6,7] European countries are more likely to use homeopathy, bioelectric therapies[2] and micronutrients.[9]

Most of these therapies are employed as adjuncts to conventional medical therapy (complementary), as opposed to those that replace standard care (alternative). Parents of children with cancer often choose CAM as a way to participate in their child's care, manage side

effects, cope with emotional effects, feel more hopeful,[6] and reduce the pain and suffering of their children.[5] Parents are educated consumers who want to assume an active role in relieving symptoms and improving the well being of their child. They need assistance to sort out the myriad resources of varying quality and to evaluate the use of CAM in conjunction with standard cancer treatment.

Despite the prevalent use of CAM in both adults and children with cancer,[10,11] however, there are few published studies documenting the safety and efficacy of CAM therapies in cancer care, and determining whether they lead to improved quality of life and positive clinical outcomes. Integrative medicine in pediatric oncology seeks to improve the supportive care available to patients, and to determine, through scientific clinical trials, which adjuvant CAM therapies are medically sound and compatible with conventional chemotherapy and radiation.

The majority of children with cancer participate in national clinical trials. In one large study, conducted by Kara Kelly and colleagues in New York, 85% of children receiving CAM were simultaneously enrolled in clinical trials for the primary treatment of their cancer.[8] How will the use of CAM therapies affect the findings of these studies? For example, is the fact that some of these children are taking the herb "milk thistle" for liver function going to influence the tolerated dose of chemotherapy agents or the incidence of veno-occlusive disease of the liver seen in some children taking thioguanine?

A debate currently rages about the appropriate role of anti-oxidants in the treatment of children with cancer. Although antioxidants appear to have a role in cancer prevention in adults,[12] the role is less clear in children and in patients already diagnosed. Anti-oxidant use often is encouraged by CAM practitioners to help combat side effects of cancer therapy. However, both radiation and certain chemotherapeutic agents (e.g. anthracyclines) exert their anti-cancer effects by causing oxidative damage. Therefore, controversy exists regarding if and when to use anti-oxidants during chemotherapy and radiation. There are few controlled studies, especially in children, and results are contradictory.[13] At the present time, many oncologists recommend that anti-oxidants (above those amounts found in a children's multi-vitamin) not be taken during anthracycline therapies or during radiation. Do we have evidence to support these practices?

The push towards integrative medicine has primarily come from patients and parents, who perceive CAM as being more patient-friendly and more natural. This natural approach is appealing because of the debilitating side effects of chemotherapy and radiation. However, because most pediatric cancers are curable with conventional treatment, the health care team must stress that CAM therapies may be at best positive adjuncts to conventional treatment. There is currently no cure for any type of cancer with complementary therapies alone and there is little scientific evidence that CAM therapies increase survival, extend life, or improve quality of life. Nonetheless, preliminary and anecdotal evidence suggests that some therapies offer relief of symptoms associated with cancer treatment.[14,15,16]

The aim of evidence-based practice is to provide the best care based on the best available research.[17] Research on CAM is needed to determine efficacy and outcomes, dosage (especially for children), provider effectiveness, cost, and mechanism of action. Pediatrics must be included in the Integrative Medicine research agenda. It is inaccurate to assume that studies of adult patients will be applicable to children.[18] Many CAM therapies are effective for symptom management of terminally ill children, and CAM options for patients with advanced disease should be expanded.[19,1] Research in these areas is especially needed.

I believe that CAM research, at this time, should focus on:

a. determining select interventions and their specific effects/outcomes under certain conditions in select populations (ie efficacy studies of those CAM practices that have preliminary evidence),
b. comparing primary or adjunctive CAM interventions to standard care in larger randomized trials in which specific CAM therapies have shown efficacy (ie acupuncture for n/v related to cancer chemotherapy),
c. establishing databases for all CAM and Integrative clinical programs so that outcomes are assessed and documented for each patient who uses any form of CAM in that institutional setting (and analyzed retrospectively for use, trends, and outcomes), and perhaps most importantly,
d. conducting studies to determine the mechanism of action of interventions on specific outcomes and testing models that include the multiple factors involved in responses to CAM interventions.

Of importance in the methodologies to study CAM is the inclusion of qualitative analysis to capture how CAM affects individuals as a whole as well as specific outcomes that aren't easily measured with standardized self-report instruments. Qualitative analysis also can help provide the clinical constructs in which to develop sensitive and valid instruments.

An example would be the assessment of the role of spiritual beliefs in health and healing. Spirituality is not easily "measured" although many have tried to do so. Assessments of spirituality naturally involve the whole person and not just a specific religious or spiritual belief system. However, global indices of health such as health related quality of life often are not specific and sensitive to CAM interventions. They are more functional rather than spiritually related. Our assessments need to reflect this integration of beliefs within the spiritual being of the individual, from the perspective of adults as well as children.

II. Issues and barriers interfere with conducting well-designed trials that determine efficacy and effectiveness.

Research in psychoneuroimmunology has provided much of the scientific evidence for the interaction among the body, mind, psyche, and spirit. Evidence for the negative effects of stress on the immune system, the relationship of stress to illness, and the ability to condition physical outcomes with psychological expectations directly emanates from PNI research. In my view, CAM research is the "intervention model" for PNI research. Whether the intervention being tested is prayer, imagery, massage, aromatherapy, herbals or nutritional supplements, a conceptual model of how the specific therapy might work drives the selection of the population studied, the mediating variables, and outcome measures. Research in CAM requires the same rigor as PNI research. Both efficacy and effectiveness studies are needed, as well as studies testing mechanism of action of individual CAM therapies.

However, CAM intervention research has many unique characteristics that make standardization of the intervention more challenging, control of patient self-practices difficult, and randomization sometimes unethical. Some of the methodological issues of conducting CAM intervention research include:

a. The level of control isn't the same. We still need randomized controlled trials, but we can't always have double-blinded conditions, and we may need to rely on statistical methods of controlling for differences, rather than restricting use of other supportive interventions used by subjects.
b. Randomization should be used when appropriate. However, adding a randomized control group would require eliminating access to the intervention. How ethical is this when your child is dying and you want to do everything possible to smooth the transition?
c. Maintaining consistency of the intervention across subjects is important. However, some level of "tailoring" of the intervention must be allowed. Energy therapies require that the practitioner be responsive to the specific condition of the patient at that moment in time. And homeopathy defies the principle of treating everyone the same.
d. Interventions aren't generalizable. What works for one individual often is not helpful to another individual. Despite the scientific strength in randomization, the power of the intervention lies in "matching" that intervention with the strengths and beliefs of the individual.
e. Recruitment is challenging. The level of commitment is often high in CAM intervention trials (Richardson, Post-White et al, 1998), and the drop-out of the "control" arm is higher than that of the intervention arm. Cross-over designs reduce drop-out, but carry-over effects are likely for some CAM interventions for specific outcome measures (ie pain – preliminary analysis, Post-White et al).
f. CAM interventions are often used in combination. New methodologies are needed to look at whole systems. Just as chemotherapy is synergistic; CAM also may be more effective when used in combination. However, we first need to demonstrate efficacy of therapies alone.
g. Ideally, efficacy studies precede effectiveness studies. It won't matter if it's cost effective if it doesn't make a difference! It is the efficacy studies that will create organizational, policy, and insurance changes.

Additional recommendations for conducting rigorous research in CAM require that:
a. outcomes are embedded in a theoretical framework
b. measures are sensitive to the intervention
c. multiple data sources and multiple methods are used to reduce bias of self-report
d. interventions are standardized, but allow for tailoring to specific client needs
e. interventions and outcome measures are sensitive, relevant, and meaningful to different cultural and ethnic groups
f. the dose, intensity, frequency, and actual practice/utilization of the intervention is defined and measured
g. new methods of analysis are developed that consider individual outcomes, not just group means (Hierarchical Linear Modeling and Growth Curve Analysis)
h. instruments are replicated across samples with sufficient power
i. mechanism of action are studied within a framework
j. the inclusion of biological outcomes tests mechanism of action and supports a PNI framework for CAM intervention studies

Study designs measuring PNI outcomes of CAM interventions require large sample sizes to accommodate extraneous factors and huge individual intra- and inter-variability. This increases the cost of the study and oftentimes reduces the chance for competitive funding (either the study is too expensive for the value of the findings or it is underpowered to test the expected outcomes). Much more funding is needed to accommodate large scale, powered, efficacy and effectiveness studies. This funding is needed now, before CAM therapies become "standard care" and patients are unwilling to be randomly assigned to groups or forego favored therapies in a randomized controlled design. And because of the methodological challenges, funding education and training for CAM intervention researchers is just as critical as the monies to fund the studies themselves.

III. Recommendations for integrating CAM research into practice and more quickly advancing the science of the field.

It is difficult in CAM intervention research to obtain large enough samples sizes that provide power and generalizability beyond a homogenous sample. Funding is one barrier, particularly when the elements of control and randomization are absent in the design. Other barriers include access to a unique population (children at the end of life in a given region), travel distances to obtain and offer interventions by select practitioners, and time commitment by participants reducing participation in trials.

Multi-site research is becoming standard when sample sizes are small. Although multi-site research brings its own issues of lack of control and standardization by site, integration of CAM interventions within Cooperative Group Clinical Trials is one way to test the efficacy and effectiveness of CAM interventions more efficiently. Mechanisms for the inclusion of biological outcomes are often already established and the clinical trial structure facilitates standardization of the intervention and procedures (by protocol). Unlike medical trials, however, CAM interventions in clinical trials would require cross-training of practitioners to ensure consistency among the interventions offered at each site.

In the forthcoming grant renewal for Children's Oncology Group (COG), funded by the National Institutes of Health, the CAM subcommittee of the cancer control group is designing group wide protocols to test the effects of specific CAM interventions on outcomes in children with cancer. The goal is to test adjunctive complementary modalities as well as specific individual agents.

Cooperative group research is credited with the doubling of survival from childhood cancer. As a cancer CAM researcher and mother of an 8 y.o survivor of leukemia (ALL), I can assure you that it is the clinical trial mechanism that saved son's life, which I am deeply appreciative of and thankful for. However, these children, as well as many adults, who survive cancer, have late effects that persist throughout their life. They learn to live with physical limitations and changes in cognitive function and school performance as a direct result from surgery, cranial radiation, or intrathecal chemotherapy. They also relive the fear and feelings of lack of control over their bodies. Siblings too are affected in many ways we do not yet understand - because they haven't been studied as much.

Imagine what differences we could make in not only continuing to improve survival rates, but also in reducing toxicities and late effects, and having a direct effect on the lives of

children, families, and adults who survive cancer. Many of the clinical trial protocols for acute leukemia in children are inching survival rates upward, trading off the benefit with sometimes increasing associated toxicities. It's a very fine balance.

Imagine the effect on clinical outcomes if we could identify CAM therapies that could reduce these specific toxicities and allow for more effective use of appropriate treatments/agents. For example, adding carnitine or Co-Q10 as a cardio-protectant to reduce the cardiac toxicity that some of these children and even more adults experience secondary to anthracycline therapy. Or investigating an herbal supplement that influences neurotransmitter and glutamine levels and reduces the neurotoxicity of intrathecal methotrexate. Or perhaps investigating specific anti-oxidant levels and supplemental dosages to reduce recurrence rates.

In the forthcoming grant renewal for Children's Oncology Group (COG), funded by the National Institutes of Health, the CAM subcommittee of the cancer control group is designing group wide protocols to test the effects of specific CAM interventions on outcomes in children with cancer. The goal is to test adjunctive complementary modalities as well as specific individual agents.

Multi-site trials exponentially increase the sample size and generalizability (with some sacrifices to intervention control that would need to be standardized). Collaborating with cooperative groups ensures access, credibility, increased sample sizes, and efficiency in recruitment, data collection, follow-up and analysis. Cooperative group trials also increase intellectual resources and provide opportunities for research questions that might be underpowered at one site or not studied at all. Think how far we have come in pediatric cancer survival since the 1970s. Think how much more of a difference we could make in the lives of children, adults, and families with cancer. Imagine where the science of CAM could be in the year 2030... It is time to critically test some of our more promising CAM therapies.

Brennan Robert White, Survivor of ALL

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

Honorable Commissioners:

It is my belief that the greatest benefit that complementary and alternative medicine has to offer us is in the opportunity to see ourselves from other perspectives. In Chinese medicine it is said that nothing brings greater suffering than the stagnancy engendered by attachment to a single point of view. There is great wisdom in adopting another perspective when it is appropriate to do so and there is great advantage in having a collection of ready perspectives from which to draw.

CAM represents a diverse collection of perspectives on a wide range of human health issues, from the treatment of illness and the prevention of disease to the optimization of health and well-being. This diversity of perspectives is the very definition of CAM and is its greatest value. It is perspective that guides the CAM practitioner in making a diagnosis and forming an appropriate treatment strategy. It is perspective that directs the safe and effective use of treatment modalities. It is perspective that helps to shape, guide and provide focus for the healing intention. It is perspective that is ultimately responsible for whatever benefits a system of medicine is capable of yielding.

Yet, as important as perspective is in defining a paradigm, it is seldom acknowledged and CAM paradigms often remain unarticulated and poorly understood. If we hope to create policy that will ensure the maximum benefit of CAM in an integrated system of health care we must recognize where this benefit lies. The benefit is in the perspective. We must do everything we can to clearly define and understand CAM perspectives so that we do not lose sight of them in the process of integration.

As we develop methods of research to determine safety and efficacy, we must do so in a way that maintains the integrity of CAM perspectives.

This will probably be very difficult to do using standard research models that tend to focus on mechanism. If we are to determine the validity of any CAM perspective it is my opinion that we must not do so in terms of conventional medicine. The validity of a perspective rests not in how well it agrees with our own, or whether we can even understand it in terms of our own, but whether or not it consistently leads to positive outcomes. Safety and efficacy of a given therapy are dependent upon its appropriate use. Appropriate use, in turn, is determined by the guiding principles of the perspective. We must encourage and support CAM research within the CAM community itself so that CAM perspectives can first demonstrate the validity of their guiding principles. If the guiding principles of a CAM perspective can be demonstrated to be internally consistent, then it may be much easier to go on to demonstrate safety and efficacy without having to research the mechanism. In this way, we may be able to meet the standards set by our society for the safe and competent practice of health care without having to compromise the integrity of CAM perspectives.

Thank you.

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

The goals and philosophy of CAM include wholeness, wellness, and healing. These are inherently expansive concepts that lead to questions of consciousness, interconnectedness, transcendence, healing, and spirituality. If we ask the questions that CAM prompts, then a methodology that supports the research to find the answers is required. The current methodology of the randomized double-blind study is serving us well in some arenas, but it is based on a reductionist model, and reductionism and wholism do not resonate.

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

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

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Presentation
for the
White House Commission on Policy
for Complementary and Alternative Medicine
Town Hall Meeting
Minneapolis, Minnesota
March 16, 2001

Excelsior

The Argument for Bottom-up System Change:

I am a mainstream, family physician in general practice, in the town in which I was raised. My office and high school and ancestral home are all within a 50 yard radius. In one sense, I am a domain expert on localness. The localness of Peter Senge.

The town is Excelsior and means "ever upward." It is the title of this testimony and an image for bottom-up system change.

When the work of this White House Commission is completed, I assume, it will have created a set of policies that address: care, education, outcomes research, organization, systems and governance. These policies will need to be integrated and cohesive and, definitely not, at cross purposes with one another.

Guidelines for the research and development of each policy will be chosen and I would like to suggest some options, mostly based on bottom-up strategies.

For organizations and systems, the 4C2A formula: comprehensive and continuing, coordinated and customized, accessible and accountable. Services and programs will be built on this basis.

For care and education, the emphasis would be on partnerships where the partners have equal power. Also, there will be replication of the 4C2A formula.

For outcomes research, a health status assessment that measures and treats both health and disease with equal intensity. Policy would direct that this be a part of daily care.

For governance, the intentional logic of Harvey wheeler where a system of rewards largely replaces regulation and punitive methods while it produces higher performance and greater patient safety. It would give concepts like the 4C2A formula the force of law.

PRIORITY OF PARTNERSHIP:

A project supported by an NIH, SBIR grant, asked patients how they got well and they said: we got better because you and your staff listened and cared; this allowed us to put in trust (and become a partner in the relationship); and this led to willingness to change our lifestyle and our lives.

A recent review of the literature on informed consent found both mainstream medicine and complementary medicine saying the same thing, i.e., the practitioner and the patient would approach a negotiation about proposed care within an atmosphere of conversation and shared exploration until they came to a negotiated consensus. To do otherwise, would make the practitioner liable. The good news is that the need for this kind of partnership extends across the whole spectrum of practitioners and could assure integration, collaboration and greater safety. This idea is already supported by the malpractice insurance carriers.

THE GROUNDED THEORY APPROACH:

The Grounded Theory Approach takes place when one goes to where the phenomenon is taking place, and becomes immersed in that environment. Examples would be: an internship, a focus group on the use of Dove soap, or a practitioner and patient negotiating a treatment plan

based on a current health status report.

Patients can be research colleagues either individually or collectively. One patient group pointed out that the SF36 (Ware, et.al.) was lacking in a spiritual health measure. Another group of patients helped develop a language of negotiation, and when this collaboration of practitioners and patients was done, the practice no longer had hypochondriacs, neurotics, schizophrenics or psychopaths.

THE LABORATORY PRACTICE:

The laboratory practice using the Grounded Theory Approach, patients as research colleagues, and the multimethond research of Miller and Crabtree, might well be the preferred option for the development of health policy that would support integration and collaboration of CAM and Medical Practitioners and their patients. Also, this method is more likely to support the CQI processes of Demming and the Mass Customization of Boynton, Victor and Pine.

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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

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.

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 and 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 fro 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 he 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 patients 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 n 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 Potowatoni 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 bate 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 seams 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]

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
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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 interferred 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
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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 then 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

Metropolitan Asian Family Service

7541 N Western Ave, Chicago, IL 60640
Phone: (773)465-3105, Fax: (773)465-0158

Dear Member of the Commission,

Now, it is a high time that United States Should recognize Natural Medicines. Alternative Medicine should be given equal consideration as regular medicine as they have pro more beneficial to care discuses like cancer. Sugar and heart condition is many other Asian &European countries Scientific generate published compelling research papers as how they are effective in treating the condition in my Indian Community we have age old Aurvedic Medicine system. I as a community reader strongly recommend that people of America should have freedom to choose their medical system and Insurance companies should also recognize this ·freedom of choice to their customs.

It is very strange that freedom and liberty the soul of this country but also people does not have freedom to choose their medical health care. This is very important to my Indian Community to use their medicine, which existed for thousands of years and they have faith and believe in them. Moreover recent Scientific research on Aurvedic medicine proves that they are more effective in Curing Cancer, Diabetes, and heart condition than conventional medicine,

Our Elderly immigrant Population is in dire need of these taditional medicine but Medicaid-medicare does not provide for those Doctors who practice Natural or Alternative medicine. Other private insurance company also does not insure these "Alternative medicine".

It is hard to believe that such an advance & democratic Society like United State during its own people their right to be healthy & happy.

We on behalf of the East Indian Community·strongly believe that People should be given freedom to choose their own Medical health System, it is the fundamental right of every Human beings.

Santosh Kumar

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.

3 minute WHC

TO: THE WHITE HOUSE COMMISSION
FROM: MARILLYN BEYER, B.S.N (1947), M.A. (1977)
PRESIDENT: MINNESOTA NATURAL HEALTH COALITION
INSTUCTOR: ANOKA/RAMSEY COMMUITY 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!!!!!!!!!!!!!!!!!!.

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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.

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Testimony Before the White House Commission on Complementary Care

16 March 2001

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Good afternoon, Honorable Mr. Chairman and Honorable Commissioners. It is my pleasure to speak with you this afternoon regarding legislative implications of our efforts to provide non-medical health care services, educational programs, and the development of collaborative and integrative provider relationships in what is essentially a highly political climate. I serve as Vice President for Institutional Advancement at Northwestern Health Sciences University, a small multi-program institution here in Minneapolis with professional training programs in chiropractic, oriental medicine and acupuncture, therapeutic massage; academic programs in undergraduate studies and a graduate program in integrative health and wellness.

I will spend my brief time with you focusing on areas of policy development that I believe would have a real and beneficial impact on improving the quality of health care to the American public with the prospect of very real cost savings.

From the perspective of CAM providers, one of the greatest potential problems is that the exciting pace of developing integrative health care initiatives is blurring a very fundamental fact: that in mainstream medicine's rush to adopt complementary practices too often the cultures that have nurtured and developed those practices are not receiving much attention. Particularly where there is a history of political adversity, respect for the intrinsic culture of professions that have been disparaged for many years is absent all too often.

We must remember that integrating health care delivery is at its heart a blending of cultures, and it is very difficult for the dominant culture—mainstream medicine—to remember the need for sensitivity and respect.

The difference between co-option of CAM procedures by licensed health professionals and the support of CAM communities to provide those procedures can be stark. Much as we have found that isolation of bioactive compounds from naturally-occurring substances provides only a portion of the full spectrum of the original effects, so too we must be careful that "CAM-grafting" practices into mainstream medicine do not too greatly limit the potential of their application. Nor must we forget that, fundamentally, clinical decision-making by non-allopathic providers utilize, in many cases, very different factors and influences that can fundamentally affect clinical outcomes.

These forces play out frequently in legislative battles as some professions seek to mature and improve the quality of patient care delivery but find themselves limited by inaccurate or misleading scope of practice laws, while other professions seek to stabilize and qualify themselves as legitimate care deliverers, but find themselves stymied and locked out by competing forces.

In Minnesota, for instance, doctors of chiropractic operate under antiquated scope laws, but find tremendous opposition from political medicine when seeking to have their laws reflect their training. Even this year, for example, in contrast to improving professional and clinical referral relationships, political medicine has sought to legislatively prevent doctors of chiropractic from using their training to provide accurate and cost-effective athletic physical examinations. This battle played out recently over truck-driver examinations as well, and was resolved in large part because of federal support for the qualifications of doctors of chiropractic to perform them.

My first policy recommendation, then, is this: there must be federal-level support for minimizing local legislative conflicts. Where licensed health professionals have educational standards based on federally recognized accreditation bodies, scopes of practices should reflect the training received, and not be contested state by state.

Professional maturation ultimately benefits the consumer. Efforts to constrain these beneficial processes add needless costs to our system. Models for this type of scope already exist in some states, and replication needs federal support.

My second policy recommendation is this: there must be federal-level support for examining the professional and historical cultures that have given rise to CAM practices, procedures and professions.

We have learned too late that careless and arrogant absorption of indigenous peoples into our northern European culture has come at a tremendous price in lost information, tradition, values, and healing arts. I submit to you that a corollary exists in health care, and the overwhelming degree of cultural dominance by mainstream medicine makes it very easy to overlook potential benefits and values of respectfully preserving aspects of the cultural practices it is interested in making use of—even when they are not well-understood.

My third policy recommendation is this: that there must be federal-level legislative and funding support for the development of non-allopathic academic health centers.

I suggest to you that there is potentially more to be gained by supporting the maturation of institutions that are educating CAM professionals than there is through co-option and absorption. Again, because the cultural differences in some cases are so great—even as they may be synergistic and complementary with mainstream medicine—but vulnerable to careless treatment, CAM educators need to be relieved of the pressure of seeking local legislative redress. Particularly when the medical system is under such evolutionary stress, resource allocation is a tremendously competitive challenge. Support for such CAM academic health centers offers fascinating opportunities for cross-training and shared clinical experiences that ultimately would benefit consumers immensely.

My fourth policy recommendation is this: there must be continued and expanded federal support through the National Institutes of Health to conduct research which examines whole non-medical health care cultures, practices, delivery methods and effectiveness by means that do not seek to extract and isolate modalities and procedures.

We already know that most, if not all, non-medical practices do not lend themselves well to randomized double-blinded placebo-controlled clinical trials. We should embrace the challenges of multivariate research studies of CAM cultures and practices.

In summary, the pressures of participating in a health care system that is under great duress play out differently with different types of providers and cultures. Where local legislative considerations figure in, particularly in areas of scope and resource needs that are very difficult to not view competitively, achievements which contribute to the greater good too often require debilitating legislative battles that result in hardened attitudes and increased resistance on both sides. Federal support that moves these discussions to a different, less-competitive level of discourse is vitally needed.

I thank you again for the opportunity to provide this testimony, and would be happy to answer any questions you may have.

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March 16, 2001

To: White House Commission on Complementary and Alternative Medicine Policy

Dear Commissioners:

I am an Oregon licensed Naturopathic Physician practicing in the unlicensed state of Minnesota. I have been in St. Paul since April of 1984.

Naturopathic Physicians have been in the United States since 1896 to foster health through the use of noninvasive methods such as sound nutrition, vitamin and mineral supplementation, homeopathy, botanical medicine, therapeutic exercise, prenatal education, natural childbirth, and more recently Oriental and Ayurvedic medicine. We also receive training in basic medical skills such as performing physical examinations and PAP smears.

I feel that N.D.s are the "original" CAM providers and the true pioneers in a hostile medical environment that is only recently seeing our worth.

While I would rather speak on how well-trained naturopathic physicians could impact the direction of health care in Minnesota, I have been asked to give my thoughts on the new Complementary and Alternative Health Care law, now in the Minnesota Statutes as Chapter 146A.

What I like about the new law is found in Subdivision 1 of 146A.02. It states that the Office of unlicensed complementary and alternative health care practice, which is within the Minnesota Department of Health, shall serve as a clearinghouse on CAM practices and practitioners through the dissemination of objective information to consumers.

I like this because I think it will raise the public's awareness of the numerous choices they have available to them for their health care. I like that it will be objective information, because I feel that the decades of bias toward any unconventional healers and their methods has been both costly and damaging.

What I don't like about the bill is that it requires each patient or client to read and sign a very cumbersome "Client Bill of Rights" prior to receiving treatment. I find the statements range from the obvious to the demeaning. I already practice by a Code of Ethics established by naturopathic physicians and the state of Oregon where I have held my naturopathic physician's license since 1983.

"Healy" continued

The state of Minnesota has not adopted any educational or training standards for naturopaths, so as a group, we find our impact is negligible when compared to the inroads naturopathic physicians have made in Washington state regarding primary care, research, and integration.

Historically speaking, naturopaths have worked toward licensing Minnesota since 1909. But other political and financial interests have defeated these attempts at recognition. According to this law, it is prohibited conduct for us to use the title "doctor," "Dr.," or "physician" alone or in combination with the word naturopath. If we do, it is grounds for disciplinary action and possibly revoking the right to practice.

This is deeply concerning, because as this Minnesota law is being touted as a "model law", it is hostile to those dedicated individuals who have attained the highest educational level available in the realm of natural medicine. It is insulting and it diminishes our worth to the point of abolishment.

I would like to see two things happen in Minnesota. I want to see a fair licensing bill introduced and passed for naturopathic physicians. And I want to see a successful naturopathic college with a 4-year program graduating competent and compassionate N.D.s.

Thank you.

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Dr. Healy is the immediate past-president of the Minnesota Association of Naturopathic Physicians

One hundred years ago, natural forms of health care were a major and integral part of our society. But you perhaps all know the story of the Flexner Report, and the tragic effect it had on the natural healing arts. The Flexner Report made recommendations regarding educational standards - that only those schools which emphasized the chemical and biological sciences would be accredited. The fallout from those recommendations was that all other schools lost funding, lost ability for their graduates to legally practice, and ultimately, closed. Educational standards eventually metamorphosed into licensure requirements, which fenced out many wonderful healers. Sadly, the knowledge and skills of homeopathy, herbal medicine, and, indeed, the philosophy of natural healing almost disappeared entirely from the face of America.

Now that we are once again contemplating the future of alternative health care, we would do well to learn lessons from the Flexner report. If we try to force the passing on of ancient wisdom into a rigid, regulated model, what richness might be lost in the process? If we license a few isolated modalites, in an attempt to promote natural health care, what will happen to the hundreds of other modalites? They are still illegal to practice? If we really think that licensure is the effective way to become mainstream, will we license Reiki? And then Qi Gong? Feldenkreis? And then homeopathy? How about aromatherapy? Healing touch? Shiatsu? Gerson therapy? Ayurvedic? Hydrotherapy? Jin Jin Jitsu? Tui Na? Anthroposophy? Colostrum therapy? How far will we go before we get weary, leaving hundreds of spectacularly effective modalities in illegal status, probably to die out completely. If we start down the path of selective licensure, we may end up destroying the healing arts, only this time, we will have done it to ourselves.

This would be a tragedy, and we must find a better way, so that the wisdom of all of the healing modalities will remain accessible to our children and grandchildren.

Recommendations for a Broadly Based and Inclusive Approach

Legal reform should be introduced in every state which would accomplish the following:

Unlicensed Practitioners

- Create a new jurisdiction for unlicensed practitioners which would provide an exemption from the medical statute for those practitioners under the regulatory framework.

- Avoid mandating a particular type or extent of education for practitioners, as long as they provide clients with truthful information regarding their education and training, and practice within reasonable conduct guidelines.

- Provide a mechanism for consumers to register complaints regarding prohibited conduct, and for follow-up investigation and enforcement.

- The definition of alternative practitioners covered under this jurisdiction should be broad enough to cover all existing modalities, as well as potential new ones. If examples are listed in a statute, language could be used which says "including but not limited to..."

Licensed Practitioners

- Create the flexibility for licensed practitioners to practice outside of the "customary standard of care", provided that there is disclosure to clients that this is outside of the standard of care, and that the alternative treatment is not more harmful than the customary treatment.

Jerri Johnson
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