# WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

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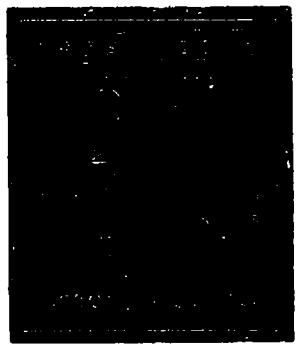

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## OPEN SESSION (Continued)

AFTERNOON SESSION

CULTURALLY-BASED HEALING TRADITIONS

MS. CHANG: Welcome back. We have got all the commissioners back from lunch and we would like to call up the next panel.

Okay. You will have to forgive me if I mispronounce your name. Okokon Udo, Michele Strachan, Thupten Dadak, Master Chunyi Lin, Jose Reyes, and Sabina Pello.

COMMISSIONER GORDON: Are we all back from lunch? Okay. Great.

All right. We will begin the afternoon panel.

Okokon Udo? Is that right?

MR. UDO: Yes.

COMMISSIONER GORDON: Okay. You are first.

OKOKON UDO, DIRECTOR

CENTER FOR CROSS-CULTURAL HEALTH

MR. UDO: I have submitted my testimony and I will be reading the introduction and the conclusion. In my introduction, which seeks to highlight something of the cultural beliefs and practices of different sections of our communities comes a lot of stories and I will

read a quick story here about the Yoruba of Nigeria.

Among the Yoruba, a traditional healing ceremony takes place in a special center adjacent to the healer's own house and may last for days or weeks. When the healer deems the patient fit to return to normal society, an elaborate discharge ceremony is performed. The rituals are done at a river in a deserted place.

The patient takes off her old clothes and puts on a new white dress. Nest her head is shaved and some small cuts are made in her scalp. The healer, her assistant, and the patient wade into the stream waist deep. The healer then takes one of three doves to be used in the ceremony and uses it as a kind of sponge, wetting it and rubbing it over the patient's body, drawing out her illness, transferring it to the dove. The dove is then drowned and its body thrown downstream along with the patient's disease, which has been absorbed.

The second dove is then killed and its blood smeared over the patient's head and upper body. The vitality and calmness of the dove is thus transferred to the patient. The patient is

washed and her bloodstained dress thrown downstream with the body of the second dove.

Back on shore the patient is rubbed with medicines and another dove is killed and its blood splashed over her body and then washed off. The patient then stands on the body of the dove and an incantation is invoked. The body of the last dove is then thrown downstream with the declaration that the dead bird carries the patient's sickness with it and that just as water never flows upstream, so the patient's sickness will never return.

The story is illustrative of the kinds of forms of healing that are being practiced in our community, which is changing very rapidly.

And in concluding my testimony I want to draw attention to a quote from a physician by the name of Deborah Prothow-Stith and in a rather related way make the application to the story I have just shared.

And she says, "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 only through public policy that we determine that." And I think it is going to be

only through public policy that we determine when we spend the money that will help bring about healing for the different sectors of our community.

Thank you.

COMMISSIONER GORDON: Thank you. Michele Strachan?

MICHELE STRACHAN, MD

POWDERHORN WELLNESS CENTER

DR. STRACHAN: Good afternoon.

I am Michele Denize Strachan and among my people I am known as "Samowid Saonca."

Cultural health practices are about songs, stories, symbols and sacred relationships. There is as much distance between them and the sound bytes required for a three minute testimony, as there is between the optimal well-being of Black people, my people, and the cultural underpinnings of Western medical science.

A vast body of literature documents that the system affords Africans and African Americans neither the access nor the outcome that it offers to people of European heritage. It is thus imperative for our survival as a

people to return to our ancestral legacies of healing.

Cultural health practices exist within a knowledge system that holds that life goes beyond and before the aliveness of the physical body and sees the person as a place, which is the intersection of powerful forces of relationship. Cultural health practices have as their aim the restoration of harmony and their processes are anchored strongly in relationships.

Our recommendations are simple. We need reconnection to heritage and the rebuilding of our cultural communities. The teaching and the support for how this is done is a cultural health intervention and should be paid for and reimbursed.

We need our cultural healers, shamans and elders because they embody the continuity of a heritage, the erasure of which lies at the root of our chronic illnesses. Education and certificating of those healers and elders belongs to the jurisdiction of a circle of elders integral to that spiritual culture.

We need health professionals to be

educated in cultural practices and that process is limited to the health professionals learning to reconnect to their own culture and understanding the cultural assumptions underlying their attitudes, beliefs, definitions of health and illness, and the way they look upon people whose cultural paradigm does not include rationality, logic, technology.

Thank you.

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Thupten Dadak?

THUPTEN DADAK

TIBETAN AMERICAN FOUNDATION OF MINNESOTA

MR. DADAK: "Trashidalak," that means greetings in Tibet.

My name is Thupten Dadak. I will be speaking about traditional Tibetan medicine.

Tibetan medicine dates back to before the Seventh Century and it has developed in Tibet with a strong Buddhist influence. It has a long scholarly and scientific tradition which was supported by the unique Tibetan monastic education system. Tibetan doctors typically studied for 30 years and were recognized in

their communities as wisdom masters, similarly to the learned lamas. The community respected doctors for their deep understanding of the life forces and Tibetan doctors 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 the Tibetan culture, especially its intellectual forms such as philosophy and medicine. Six thousand monasteries were destroyed and thousands of Tibetans were jailed or killed. The Dalai Lama led many Tibetan people into exile in Indian as a means of survival.

Tibetan medicine has survived into the 21st Century due to the Dalai Lama's wisdom and he ensured the transmission of the surviving master physicians' knowledge to a new generation of young doctors educated in exile.

The physicians of Tibetan Medical Institute have actively participated in East-West dialogue with the most respected medical institutions all over the world. In 1998, 120 scientists and 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, FDA recently approved the Tibetan medicine for breast cancer research trial.

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 academic settings away from the commercial pressure. The future contributions of Tibetan medicine in the treatment of cancer, AIDS, heart disease and so on are not yet known but the Tibetan text speaks of these diseases and their treatment. Every year, Tibetan Medical Institute is approached by large pharmaceutical companies with offers to purchase its medicines but the Institute has declined the offers due to the responsibility to preserve the integrity of Tibetan medical tradition.

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

Thank you.

COMMISSIONER GORDON: Thank you.

Master Chunyi Lin?

MASTER CHUNYI LIN

FOUNDER: SPRING FOREST QIGONG, INC.

MASTER LIN: My name is Chunyi Lin, the director of Qigong Program at Anoka-Ramsey Community College.

Through my observations, the health system in the United States has only been focusing on integration in the hospital and clinic setting. It seems to me that the 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.

The hospital/clinic setting is a great tool to help people get well but the most important thing is to help 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.

The Chinese have been practicing Qigong over 5,000 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, Tui Na, Guasha, massage and Qigong. Many health problems are taken care of before they grow bigger and 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.

As a Qigong master, through my many years of experience, the purpose, the dream for me to come over here to this country, the development of a Spring Forest Qigong, that is my technique, is a healer in a family and a world without pain.

Through the last five years teaching at Anoka-Ramsey Community College -- now here I am going to give you some numbers. In 1995-96

academic year I have only 100 students. Then the next year 113. Then in 1997-98 I have 1,250. In 1998-99 I have 1,525. And in the last year I have 2,400 students. So in the past few years, Spring Forest Qigong has already helped lots of people and healed their pains and aches.

So -- and here is my suggestion:

I recommend that as all cultures be respect in this country, all forms of healing be acknowledged and allowed in this country, too.

I recommend that all forms of healing be encouraged and free so that individuals can utilize for their own health and self-healing so that people be allowed to take responsibility of their own health and self-healing.

I recommend that we have a positive cultural climate and information with other cultures and reap the benefits of wisdom for all cultures.

And I recommend that the government not put legal barriers up regarding Qigong so all persons can always teach and practice Qigong.

Thank you.

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Jose Reyes?

JOSE REYES

ITZAMATUL ITOLIXTLI DANZANTES

MR. REYES: Thank you.

My Dakota name is Zuzuhichiday Hinyukan Boy.

My Toltec name is Quetzlequail Boy.

My Mayan name is Kulkukan Boy.

It means Feathered Serpent Boy.

I am an Aztec dancer of the Moshika Nation. A pipe carrier and a sundancer of the Lakota Lakota Nakota Nation. I am not a medicine man or a curanero.

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, affect 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 Red race.

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

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

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

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

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

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

We indigenous people see no problem with

the use of alternative medicine to help people with their various illnesses.

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

The solution: No laws or regulations in the attempt to control and manipulate the use of alternative medicine as practiced by indigenous people of this nation.

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Sabina Pello?

SABINA PELLO

AMERICAN ASSOCIATION OF IMMIGRANTS FROM THE FORMER USSR (ILLINOIS BRANCH)

MS. PELLO: Mr. Chairman and members of the Commission, I am authorized to represent the branches of organization from many states of USA, grassroots, not-for-profit Russian speaking immigrants, about 400,000 people.

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 our attention. Many of you may 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, citizens already, 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 health care 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 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 of 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 by their doctors. What a travesty that the traditional, natural and more effective option is not available to them.

My organization attempts to intervene on their behalf by providing our elderly with sessions of healthy lifestyle, nutritional ABCs, and some common sense natural preventive measures. However, there are still many among them who still have no access to the traditional products that they desperately need. These people cannot perceive why a democratic and

humane society is denying them their right to be healthy and happy or why costly allopathic care is being forced upon them when they desire access to centuries-proven and less expensive natural methods.

We believe that every person has the right to choose his own form of health care in a free and democratic society. Health care is a personal right, just as the freedom of speech and particularly of such a vulnerable elderly as our immigrants are.

Thank you.

(Applause.)

COMMISSIONER GORDON: Thank you.

(Applause.)

DISCUSSION

COMMISSIONER GORDON: Thank you. Thank you all for your eloquent speaking to the same fundamental issue with many different voices and many different accents. A very powerful message for us and I hope that we hear it well.

The message is that every one should be free to practice his or her indigenous traditions. That I hear.

I want more from you, though, as well.

Mr. Udo mentioned this at the beginning. What can we do? How can we as a commission help at the level of policy? What thoughts? What suggestions do you have for us? What kinds of policies would facilitate your practice, make it easier for people to avail themselves of healing from you and from other traditional healers?

MS. STRACHAN: I can start. I am the director of medicine of the Powderhorn Phillips Cultural Wellness Center, a community-based center in South Minneapolis. The bulk of cultural traditions have interventions that I alluded to when I talked about reconnection to culture and rebuilding of communities. These interventions basically is the building of a culturally specific network system and it is -- it is not only innocuous, it is evidence-based as we were talking about this morning, in terms of the body of literature that says that isolation is associated with poor outcomes.

So it is a proven measure. It is innocuous. Cultural elders are best suited to provide it to people of that culture and I believe that to allow for recognition of that and payment for it when the bulk of people of a

culture either are receiving federal assistance or Medicare or other forms of payment for their health services.

COMMISSIONER GORDON: I appreciate that. What would that look like? How would you see -- how would you see that payment coming? Do you understand what I am saying?

MS. STRACHAN: I understand what you are saying.

COMMISSIONER GORDON: What would be the kind of exchange that would take place from your point of view?

MS. STRACHAN: It is a healing intervention. It is a unit of time and it gets billed to Medicaid, Medicare or other forms of state supported medical insurance for that intervention.

COMMISSIONER GORDON: Is there any precedent now for that in Medicare or Medicaid?

MS. STRACHAN: I do not know of any. There is in Minnesota something called the unlicensed mental health provider and I do not know their rate of reimbursement.

COMMISSIONER GORDON: I do not think they have -- I do not think they have come to

that question yet and I do not think there is any at this point.

Yes?

MS. PELLO: I think it is very important to give the access for Medicare for payment for people because the modality is extremely popular among the Russian speaking and people from East Europe. So it is the only problem to be covered by this and people will come --

COMMISSIONER GORDON: The only problem is?

MS. PELLO: To cover financially.

COMMISSIONER GORDON: Financially.

MS. PELLO: Medicare and Medicaid.

COMMISSIONER GORDON: We are going to need help with this in terms of figuring out how to do it. I hear the message. There has -- you know, I think it is going to be a struggle in any case, which I am sure you know, but I think the more clearly you can help us formulate some of these thoughts about how payment might come -- so it would be a center -- the other possibility that came to my mind is the funding of a center which, in turn, would then provide services rather than trying to go -- because the

payment means may be so complex. Do you understand what I am saying? Because it is --

MS. STRACHAN: Actually I am not sure that I understand your question. On the one hand you are saying how do we do it but on the other hand what I am hearing is how you want to do it is not acceptable to the existing financial structure and so I am not exactly sure how to help you make it acceptable.

COMMISSIONER GORDON: That is what we are asking. One thought I had was to make as one possibility the funding of specific cultural centers of the center rather than a fee for -- because your funding, as you describe it, particularly your funding is a set of -- it is a set of relationships, a ritual and practice that is healing.

MS. STRACHAN: Yes.

COMMISSIONER GORDON: The culture and the community. So it may make more sense to think about possible funding of that community or that particular, you know, healing community.

MS. STRACHAN: The cultural wellness center has existed for about five years now and

it is interesting that you mentioned funding of the center because in terms of health care and reimbursement for health care, it is the existing structures that drive us in terms of a mentality for fee for service, which does not fit what we are doing. It is very difficult as a matter of fact to present to funders or to insurance companies or to major companies or organizations the idea of funding a center.

You know we get all kinds of raised eye brows about operational expenses and wanting to know the very specifics of what would be done where our view is what you describe and much more holistic so I think that would fit much better our philosophy and our way of doing things.

COMMISSIONER GORDON: How do you get funded now?

COMMISSIONER JONAS: Yes, that is what I am wondering.

MS. STRACHAN: It is a wide -- it is a wide array of contracts and philanthropy and grants.

COMMISSIONER GORDON: Maybe we should ask that question of all of you. How are you

being funded now?

MS. PELLO: Excuse me. We are a not-for-profit organization. We are volunteers. I am a -- you know, a natural health professional.

COMMISSIONER GORDON: Come a little closer to the mic.

MS. PELLO: I am a natural health professional. I am doing it as a volunteer. I am an MD also but I do not have license so this is the problem. Licensure and financial together. This is the two problems.

COMMISSIONER GORDON: Yes?

MR. DADAK: I am founder of Tibetan American Foundation. In 1992, the Congress allowed 1,000 Tibetans to come to the United States and Minnesota is one of the largest Tibetan communities since 1992 and we have almost 700. And earlier I was the only -- practically myself. I have been here since 1985. And what I have seen, we have -- the community has a lot of Tibetan professional doctors and a lot of spiritual teachers.

And due to the -- due to the shortage of funding they are working in hotels, housekeeping, that kind of -- it is a sadness

because we do -- it has to be integrated with the Western and the ancient philosophy, and make this world healthy and to live, everybody, healthy. Instead those people who have knowledge, they are -- instead of serving us, they are working in housekeeping. It is something that we should -- must do something about.

There -- it is not only Tibetans. There must be other ethical -- a lot of other countries who have special professionals like that.

COMMISSIONER GORDON: Yes?

MR. _____: I think from a funding standpoint you are going to hear similar kinds of stories but I wanted to comment on a different aspect of what I think can be done at policy level.

What we hear from time-to-time from the standpoint of what my center does, which is providing information, training, research and consulting on the role that culture plays in health, is that we are talking about this issue and dealing with it within the context of a society that is divided where people still talk

about some modalities that are right and others that are wrong, some that are good and some that are bad. And so we have not even reached that level of openness in accepting that there are other ways of going about health and healing.

So from a policy level I think there is something that can be done in terms of opening up the arena a lot more, thinking about how to integrate some of these modalities into how we train professionals because these professionals are not going to be doing their work in a vacuum. They are going to be doing their work within a context of a society that is very, very diverse and so how can we prepare everyone to respond adequately to the needs that are around rather than funding one center, which may be a very small center to deal with an issue that is much bigger and broader.

MR. REYES: If someone has an illness you will approach me with an offering of tobacco. Tell me what the illness is and I will set up a ceremony for it, a healing ceremony. Funding, I am not asking for any funding. I want freedom. That is all I want.

(Applause.)

MASTER LIN: As far as I know, in the United States there is only one title like mine. In the United States in the university level, the director of Qigong Program in a college. I think this is very important and helps people to understand Qigong, help people to understand these modalities of healing, through the college curriculum, educate people and have people be aware -- more aware of these modalities of healing, helping society to stay healthy. I think that is the number one important thing.

The second is teach doctors, nurses, help them to understand these different types of modalities of healing, like a Qigong and Tibetan medicine, and medicine from different cultures. I think that is also important, too.

Then the freedom of medicine practice will come.

COMMISSIONER GORDON: Okay. Thank you.

Linnea?

COMMISSIONER LARSON: You have asked them what I had.

COMMISSIONER GORDON: Joe?

COMMISSIONER PIZZORNO: Two questions. First -- I am not as facile with names, ma'am,

but you are very eloquent. The question is are you familiar with the medical savings plan and would a methodology like that provide the freedom for people to access the cultural healing that they were looking for?

MS. STRACHAN: I think it is a beginning. I think the majority of the people from our cultures are not in the kinds of positions where they would be offered medical savings plans.

COMMISSIONER PIZZORNO: And then you, sir, when I think about a tradition like Tibetan medicine and how to keep it alive into the future, I have a perspective. I would like to hear what your perspective is. My perspective is I would look for the textbooks, I look for the faculty, I would put them in an academic environment and a formal training program with clinical training and such, and give them some kind of a credential upon completion of that. That is what I see. So a question I would ask you is what do you see for keeping the medicine alive and if we were to take a pathway like I suggested, are the textbooks there, are the faculty there to recreate this medicine in this

country?

MR. DADAK: It is a very sensitive issue because we do not have no country. One thing is that our tradition is destroyed. So we -- a handful of Tibetans who live outside Tibet has great responsibilities to keeping medical traditions, spiritual traditions alive, and that is -- as like for here in Minnesota, I am the director of Tibetan Education Action. That is what I do. The Dalai Lama's personal doctor, he is almost 80 years old, and we bring here to educate the younger Tibetans as well as the Westerners who can follow are able to -- this richness of Tibetan medicine as well as spiritual, you know, training can be strongly alive outside Tibet, not inside today. So if we might be able to go back to Tibet, we are going to -- thus the younger generation will be able to lead all the Tibetan traditional and spiritual life.

MR. _____: Can I comment on that? I think what we are asking for right now and is trying to subject a different healing modality to standards that are very, very different and in some ways alien. And we are trying to

subject other healing modalities to the biomedical healing modality and structure for training. In most traditional cultures people came to be healers from a long process of mentorship and orientation that took years, sometimes longer than what it takes in the medical school.

And so we will need to set up a different set of standards for testing, for approving, for standardizing other forms of treatment that are not going to be the same as the biomedical standard.

COMMISSIONER GORDON: Thank you.

Wayne?

COMMISSIONER JONAS: Yes. I would like to move from funding to freedom since this is supposed to be the land on which that ideal is being espoused and apparently one of the current laws in this state is designed specifically to provide freedom for nonlicensed practitioners to allow them to practice. And I would be very interested if the panel would comment on whether they think this law is of benefit to them, their particular group and particular practice, or not?

Mr. Reyes?

MR. REYES: I have not seen this law. I have heard about it but I have not seen the law. I have not read it so I do not know what it really says about how free we are to practice so I could not really comment on it.

COMMISSIONER JONAS: We could provide you with a copy and a discussion. I would be very interested in your opinion. There are some regulations involved. Obviously it is not completely open. However, it is different than what some of the current licensing laws are for saying you are now licensed to be a practitioner.

Any other reactions to the law in terms of how this may or may not have any impact on your cultural practices?

MASTER LIN: From my classes I heard more people talking about this law, doctors who refer them to Qigong classes, to take classes, and to help them manage their pain and stress. Before that I did not hear too much about people coming -- like doctors or professionals from the medical field referring people to a class like this.

MS. STRACHAN: I think the law creates a space that might be helpful to us in the future. There is an overall climate in our cultures that laws are used against us and not for us and so it is there. I think the intent of the law creates a space that will be helpful but it is going to take a while and I do not know how specifically it is relevant to us except in that sense of creating a space that would be helpful over time.

COMMISSIONER JONAS: If I may back up just a little bit then. Again, funding aside -- let's not talk about funding but freedom. Do you perceive that your practice is restricted in a way that requires some opening up or are you able pretty much to do what you feel like you need to do within your communities?

Is there any need for opening up of any restrictions? Do you feel restricted? Are you able to practice in your communities adequately?

MS. PELLO: Of course, yes. I am from Illinois. It is restricted in Illinois. We do not have license. We will not be given license if we are asking for. It is the law in Illinois and in different states the same situation. Of

course, this is a stopper.

COMMISSIONER PIZZORNO: So has there been persecution or prosecution?

MS. PELLO: No. You know, I am knowledgeable enough not to open my practice not having a license.

COMMISSIONER PIZZORNO: Okay.

COMMISSIONER JONAS: I would be very interested to hear from others.

MS. STRACHAN: I think pretty much the general practice is to practice underground so we are relatively free within our communities to do things underground.

MR. _____: According to what the law used to be, it used to be if I was caught doing what I do I would be in jail. So we do not -- I do not see setting up a school or a place to teach because we teach out there. Our way of teaching is not the college or the university. We teach in our lodges and our homes out there with the Creator and that is how we teach. As far as giving degrees or licenses, we do not have -- there is no graduation or license in our way.

COMMISSIONER JONAS: You would be in

jail because you would be accused of practicing medicine without a license, is that correct?

MR. _____: Right.

COMMISSIONER JONAS: Okay.

MR. _____: And not only me but many of our people, of our leaders, our medicine men, our curaneros would be in jail also.

COMMISSIONER JONAS: Right. So you do feel like you are at risk if you were to come out from underground of being accused of practicing medicine?

MR. _____: We not only feel that risk. We are at risk. We know that.

COMMISSIONER JONAS: Are at risk, okay.

MS. _____: We are giving our people consultations and telling them only half of the truth, not the whole truth. I cannot do this. I can give only recommendations, nothing else. And I am telling them please do not cancel your medications given by doctors and do not interfere with your medications with doctors. So this is very -- you know, an issue.

COMMISSIONER GORDON: So are you -- go ahead. I am sorry. Go ahead.

MS. STRACHAN: It reminds me of a

question that was raised this morning about pediatrics and the lack -- the differential in interest for pediatric patients. In the care of children there is this further complication, this layer of the child abuse and medical neglect laws so that if a parent chooses a cultural way of healing their child, that child can be taken away from them.

There is this further legality which puts both the practitioner and the parent at risk, which further restricts what we can do culturally.

COMMISSIONER JONAS: My perception of the Minnesota law is that it is an attempt to address these areas but I am not sure that it actually would in your particular situations and I would love if someone from Minnesota would work with the groups on this panel to help let them look in detail at the law to see if this has been, in fact, incorporated in or, if it has, if we can maybe hear from them at some point.

COMMISSIONER GORDON: Yes.

George, do you have a final question?

Okay.

I want to thank you all very much, especially given the situation in which there is the kind of risk that you are talking about, at least potentially for some of you, and I appreciate your coming here and talking with us.

I do feel it is very much our responsibility to try to work with you to help create the free space where you can do your work. I have one quick question that I want to ask, which is on the other side of the issue.

I have spent time working with Songomas in South Africa and one of the things that is going on there, particularly because of the epidemic of HIV and AIDS, is there is a feeling that traditional healers, the traditional healers association shares, the traditional healers need to know enough about Western medicine, and it is particularly about public health, to be able at least to make referrals.

I am wondering if any of you have -- and so there is a program of education in South Africa so that traditional healers will know when to appropriately refer. And I am wondering if you have any thoughts about that.

MR. _____: I think it is very

classic that when two cultures meet both cultures are transformed and so we are not talking about one culture traveling all the way to meet the other culture in that home space. We are talking about both cultures being in dialogue and I think some of that I think should be brought into the process is self -- yes, a self-critical kind of focus that enables the biomedical system to say, "Wait a minute. How can we open up? What do we need to let go of that will not affect the main body of medicine?"

And in a similar way that the traditional modalities can be asking the same questions. What do we need to know that we can add to what we already know so we can work effectively with some disease conditions that are manifesting?

So it is a shift and a meeting, I think, somewhere in the middle rather than in the either/or places that we are used to.

COMMISSIONER GORDON: Thank you.

MS. STRACHAN: I want to echo my brother's comments. I do not think that traditional healers need to be educated as to when to refer.

If the conventional medical system did not punish the cultural practitioners there would be an open atmosphere of exchange. We all know when we are beyond our ability to help somebody and the barriers that exist are barriers of intolerance for another cultural viewpoint.

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Any other comments about this?

MS. PELLO: I think it is absolutely necessary for a natural healer to know the Western medicine, to know everything, and to use the best from everything. Not to make like MD or DO/MDs. This is not -- maybe not for 21st Century.

I think it is necessary to be very educated in all medicine, you know, if it is possible.

COMMISSIONER GORDON: Thank you.

Thank you all.

We would like to be able to ask you as we move ahead to come back to you and ask you for suggestions in how to remove some of those

barriers that we were discussing and make this process of mutual understanding greater and create more space for freedom.

So thank you all very much.

(Applause.)

* * * * *

REGULATION

MS. CHANG: The next panel is Tom Hiendlmayr, Michael Myers, Michael Kleiner, Rob Leach, Marillyn Beyer and Rebecca Frost.

COMMISSIONER GORDON: We will begin with Tom Hiendlmayr.

TOM HIENDLMAYR

DIRECTOR, HEALTH OCCUPATIONS PROGRAM

MINNESOTA DEPARTMENT OF HEALTH

MR. HIENDLMAYR: Good afternoon.

My colleagues and I will be establishing in the 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 1st of this year.

We have had several questions about the start-up and operation of the office, and I thought I would tell you a little bit about how we are answering those concerns.

As you may know, the regulatory scheme for the office is based on a 1998 Minnesota Department of Health policy study on complementary and alternative medicine and on a model for regulating unlicensed mental health

practitioners that the department has conducted for the last ten years.

Susan Winkelmann in our office has a decade of experience managing that activity and, excepting the different subject matter, the new activity will be 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 particular problems with implementing this regulation.

We intend to use public service announcements and news releases to the many media resources in the community. Many providers of complementary and alternative modalities advertise in local publications and others have called the department already so that we are building a mailing list of interested persons and organizations.

There is, however, this idea that if we do not regulate practitioners and do not have a requirement that they file or register with the department that we cannot regulate them and in practice it is consumers and other practitioners tell us what we need to know and this is what occurs in those regulatory schemes for licensed

practitioners.

I think another concern that we have heard is, you know, how does the law -- how is the law going to keep people from doing whatever they want to do if there are no standards of practice to enforce.

IN fact, there are 24 professional and ethical standards of practice in the law and our experience in regulating five health related occupations over the years has been that in most cases our investigation and enforcement activity concerns noncompetency related issues. Consumers are harmed by violations of ethical and professional standards, not competency standards.

That -- I will conclude my remarks there.

COMMISSIONER GORDON: Thank you very much.

Michael Myers?

MICHAEL MYERS, JD

CHAIR OF HEALTH SERVICES ADMINISTRATION

UNIVERSITY OF SOUTH DAKOTA

MR. MYERS: My name is Michael Myers and I chair the Health Administration Division at

the University of South Dakota.

I am a former CEO of Mayo-St. Mary's hospital in Rochester and I have been on the boards of the Mayo Foundation, the Minnesota Hospital Association and the Minnesota Blue Cross/Blue Shield.

I am 64, the father of seven. I am a prime example of the cost-effectiveness of alternative health care. I have been to a doctor once in the last 45 years. I use vinegar, bungee cords and Chinese breathing to stay in good health and I lead my students in 20 push-ups at the beginning of each lecture and when I reach Medicare age in July all I will need is $25 for my vinegar and bungee cords.

I have been on both sides of this issue and for three years I was a -- I hosted a talk radio show that became a platform for alternative practitioners, including the Minnesota Natural Health Coalition.

I wish to offer the Commission three recommendations plus a reading assignment when you are flying back and forth on those planes.

(1) Fund two or three demonstration clinics with an integrated staff that include

both conventional and alternative practitioners and provide them with clinical parity, and conduct objective clinical trials.

Several years ago a surgeon, a naturopath and I failed in such an effort but you could make it happen.

(2) Identify two or three employers and research the cost-effectiveness of defined contribution plans with a medical savings account feature giving employees full discretion in the selection of therapies. That is at the heart of it all.

(3) Look to the Minnesota Freedom of Access to Health Care Act as a model for removing natural health practitioners from the jurisdiction of the state medical board.

And now for your reading assignment:

(1) Medical Nemesis: The Expropriation of Health, Ivan Illich, describing the medicalization of America.

(2) Rand Corporation research led by Dr. John Wennberg of Dartmouth, Exploring the Black Box of Medicine.

(3) Rats, Drugs and Assumptions, Majid Ali, MD, describing the pharmaceutical

industry's grip on medical education.

(4) And then you might reread Milton and Rose Friedman's Freedom to Choose.

And, remember, take your vinegar.

(Applause.)

COMMISSIONER GORDON: Michael Morris Kleiner?

MORRIS MICHAEL KLEINER, PhD, PROFESSOR
HUBERT H. HUMPHREY INSTITUTE OF PUBLIC AFFAIRS
UNIVERSITY OF MINNESOTA

DR. KLEINER: My name is Morris Michael Kleiner.

COMMISSIONER GORDON: Okay.

DR. KLEINER: And I am an economist at the Humphrey Institute of Public Affairs and also a research associate at the National Bureau of Economic Research in Cambridge, Massachusetts.

The study of occupational licensing has a long history in economics really dating to the founding of the field. The basic findings are that there are fe benefits of licensing relative to, for example, the certificating of an occupation. The sort of thing that has happened in Minnesota with the recent passage of the act.

Studies in the economics literature summarized by Simon Rottenberg in a book that he edited entitled Occupational Licensure and Regulation found some important impacts of occupational licensing which I would like to briefly summarize.

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 those who get their services.

Second, the public interest defenses for occupational licensing is of questionable merit. Lobbying and the percent of an occupational association's budget allocated to political activity often determines whether that occupation get licensed.

Third, whether licensing results in improvement in the quality of service is debatable. It is not certain that the quality of a service is improved if a license is required for the performance of an occupation and often low-income individuals suffer the most because they cannot obtain the service of a

higher priced licensed service.

Once an occupation is licensed there are often many restrictions of entry for others. The enforcement of the monopoly right of the 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.

Licensing boards and licensed occupations are frequently comprised of 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 the 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 occupation.

The manipulation of the pass rate is evidence that examining boards administer licensing legislation primarily to protect the incumbent practitioners in the occupation.

I will continue later.

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Thank you for going as far as you went.

Rob Leach?

ROB LEACH, EXECUTIVE DIRECTOR
BOARD OF MEDICAL PRACTICE

MR. LEACH: Mr. Chairman, members of the Commission, thank you.

My name is Robert Leach. I am the Executive Director of the State Board of Medical Practice, also known as the least popular person in the room.

(Laughter.)

Members of the Commission, the Minnesota Board of Medical Practice is a state agency charged with the regulation of physicians and five other health care professions, including acupuncturists and traditional midwives.

The Medical Board 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 credentialing 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.

Credentialing 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.

I do not want to be misunderstood when I speak to credentialing. I do not imply that I feel that credentialing is appropriate for all alternative health care practices but it certainly is appropriate for some.

Under the Medical Practice Act the board's statutory responsibility is public protection. The board feels strongly that the credentialing 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 credentialing 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 helps to ensure that they are safe to practice.

Credentialing 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 methodology, 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 Medical Practice Act as currently written.

Holding one's self 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 under the Medical Practice Act.

The theory behind this enforcement is that utilization of the title of "physician" can be misleading to the public in terms of the individual's 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 those restrictions.

COMMISSIONER GORDON: Thank you.

Marillyn Beyer?

MARILLYN BEYER, RN, BSN, MA

PRESIDENT, MINNESOTA NATURAL HEALTH COALITION

MS. BEYER: I am the President of the Minnesota Natural Health Coalition and I am also teaching at Anoka/Ramsey Community College now a course called "Energy Healing," and I am going to do a little one-up-man-ship here. Okay.

I am 76 years old and within the last three --

(Laughter.)

MS. BEYER: No arguing that.

And within the last three years I have had improvements in three major problems that I have had. One of them all my life. So I can speak to the fact that incorporating the natural therapies into a health care plan can produce improved health and reduce costs.

But one aspect of licensure that has often been ignored is the fact that it has politicized the delivery of health care and it has been very difficult for me and the Minnesota Natural Health Coalition to watch some of the process that occurs as a part of people trying to achieve licensure bills. It turns neighbor against neighbor, friend against friend, and it is not a good process to watch.

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.

So this is very inefficient and it is very, very costly.

Now as consumers, which is the group that I represent, we urge you to find ways to accomplish the following:

First of all, keep all natural health care providers free from arbitrary educational standards. This means no licensure or regulation. This should also include our licensed people. Actually our bill included the license. We wanted both licensed and unlicensed people to be protected by our bill but the licensed people were removed.

(2) Fund natural health education as it now is and has been for generations. This model, as the previous panel discussed, has by and large been conducted in a noninstitutional setting.

(3) Develop a task force to review the literature on natural therapies. Authorize covered benefits for those which have shown good results. I remember seeing research done with Blue Cross/Blue Shield of Iowa which showed significant savings and actually the savings increased as the individuals aged in their study

and yet this research has been totally ignored.

(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.

I have more recommendations but I will defer and thank you for the opportunity to present to you today. We hope that we can continue to have a relationship with you.

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Rebecca Frost?

REBECCA FROST, RMT, CMT

INTERNATIONAL SOMATIC MOVEMENT

EDUCATION AND THERAPY ASSOCIATION

MS. FROST: Distinguished members of the Commission, I am Rebecca Frost, the liaison for regulatory affairs for the International Somatic Movement Education and 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 a second I would like to engage your attention in the large and long visionary nature of the work we are all engaged in.

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. These have been outlined in previous testimonies elsewhere.

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 limited access for some.

Certainly there are diverse positions

within this field. I am attempting to provide some context and perspective.

Since I have had the benefit of reading transcripts of previously testimonies, I know one question you have 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 have 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 on 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 National Commission on CAM Classification, not Category V-Manipulative and Body-Based systems.

(6) Develop and fund research models appropriate to the somatic field; increase the variety of research models accepted by the National Commission to include qualitative studies, combined quantitative and qualitative

approaches, and single subject analyses as well as multivariate analyses.

Thank you for your attention.

DISCUSSION

COMMISSIONER GORDON: Thank you.

Thank you all. This panel and the one before just -- the quality of the panelists and the presentations has just been terrific all day long so I want to thank you all and I want to thank the planning committee again.

(Applause.)

It is so helpful to us.

Linnea, do you want to begin?

COMMISSIONER LARSON: I will end.

COMMISSIONER GORDON: You will end. Okay.

So we will begin -- we will go with Joe and then we will go around in a circle.

Joe?

COMMISSIONER PIZZORNO: For Rob Leach. We have been hearing a lot of testimony that licensing has no value.

COMMISSIONER GORDON: Joe, make sure your mic is on.

COMMISSIONER PIZZORNO: We have had a

lot of testimony that licensing has no value. Would you present what you believe to be the value of licensing?

MR. LEACH: Mr. Chairman, members of the commission, as I stated in my written statement, when you have a regulatory agency whose statutory charge is public protection, I think that that does serve to benefit the public in terms of having an authority to go to when someone is not practicing safely and to have standards set, entrance to practice standards, to have verification of those standards. Rather than have individuals hang up a shingle and claiming that they have so much education, so much experience in a certain health care field, you have a state agency that is able to -- through its resources verify those credentials and make sure that the individual has met the standard -- minimum standards of practice in the state. That is the primary benefit.

COMMISSIONER GORDON: Anything else, Joe?

Wayne?

COMMISSIONER JONAS: Yes. I think if we wanted to see not exactly what it would be like

without licensing but maybe a vestige of that, we could look back before medical education reform in which in this country there were many, many eclectic providers of all types that could purchase and practice, usually purchase and then practice their profession all over the place and I think it was because of that Wild West attitude in the variety of forces that impinged on that that the whole system of licensing and quality assurance of training emerged.

Mr. Kleiner, I have one question for you, and if you cannot answer this question I do not think there is anybody in the world who can, and maybe there is no answer to the question which is an acceptable answer I suppose.

Has there been any objective systematic study of the impact of licensing, especially on kind of its key component, which is protection?

I will stop there.

DR. KLEINER: There has been -- most of the studies have been on quality, that is people who get licensed versus nonlicensed, more or less regulated kinds of services on the quality that individuals receive. There has not been -- there have not been studies on the effect of

catastrophes. For example, if an unlicensed -- one could do the thought experiment of an unlicensed person who would not see the spread of a disease, as a consequence the disease decimates a population, and that might be a potential impact of licensing. Those kinds of studies have not been done.

But there have been many done on quality of care received by consumers especially in the area of dentistry where there really has not been much of an effect of more restrictive licensing standards on the quality received by consumers.

COMMISSIONER JONAS: Beyond a certain level?

DR. KLEINER: Right.

COMMISSIONER JONAS: Has anyone looked at licensed versus unlicensed practice types of situations to look at both quality and adverse impact or adverse outcome?

DR. KLEINER: The only -- physical therapists. There have been some studies done in that area and the results are fairly murky in terms of have there been any major effects of licensed versus nonlicensed occupations on the

quality of service. Most have been done on the effect on earnings and what happens to individuals who are able to become licensed and certainly there are benefits to that.

COMMISSIONER JONAS: Well, I think this would be useful to do. I know, for example, in England there is -- you can pretty much hang up a shingle and practice anything you want and I am just wondering if there is anybody who has looked at that situation compared to a more -- to licensing, period, and the various level of restriction. And it seems to me that in Minnesota you are about to begin a similar experiment and I am just wondering if anyone is evaluating that.

DR. KLEINER: To my knowledge, no one is evaluating that tissue in Minnesota. It would be a great research project.

COMMISSIONER JONAS: Yes, I would think so.

(Laughter.)

COMMISSIONER GORDON: George?

COMMISSIONER DeVRIES: Mr. Kleiner, you have obviously outlined the pitfalls of licensure and that maybe it is not the perfect

model but what is the perfect model that protects patient safety for the public?

DR. KLEINER: Well, one needs to -- and this is sort of on the one hand, on the other hand. There is no perfect model. Certainly one wants to have consumers have the full range of options and one model might be certification where the state says that -- or keeps track of individuals who have obtained certain levels of education and training.

Consumers can check to see if an individual has that level of training. And if an individual says they do and they do not, they can be sued or thrown in jail, which would be the case with fraud. So that might allow greater choice by consumers to go to someone who is licensed who might charge more or go to someone who has lesser qualifications and training but may be able to help them at a lower level.

COMMISSIONER JONAS: Yes?

MR. LEACH: Mr. Chair and members of the Commission, I would like to address that and I do not know if I made it clear in my statement that in Minnesota we have licensure and

registration, which is exactly as the gentleman was talking about. And certainly when I was talking about regulation of alternative and complementary practitioners, I was referring to both licensure and registration of those individuals. We do not call it certification here.

COMMISSIONER GORDON: Linnea?

COMMISSIONER LARSON: I do not have any.

COMMISSIONER GORDON: I have a question for Mr. Hiendlmayr. Two questions really.

The first is how did you happen to get the job?

(Laughter.)

COMMISSIONER GORDON: I am just curious. I am curious about it because it is such an interesting -- such a kind of wonderful, interesting and challenging position right now.

MR. HIENDLMAYR: I am not sure what you are asking me, Commissioner. In terms of how did the health department receive responsibility for this or how did I get my job?

COMMISSIONER GORDON: No, no. No, you in particular. I am curious. Just curious how you happen to be in the position.

(Laughter.)

COMMISSIONER GORDON: I understand how the health department got responsibility.

MR. HIENDLMAYR: I never applied and I was -- I never had to qualify for it.

(Laughter.)

COMMISSIONER GORDON: And you do not have a license.

(Laughter.)

MR. HIENDLMAYR: I am a licensed attorney by training.

COMMISSIONER GORDON: Oh, you are. Okay.

MR. HIENDLMAYR: I make good use of it.

COMMISSIONER GORDON: Were you interested in this particular field before? I am just curious.

MR. HIENDLMAYR: I began my career in program evaluation and moved to the health department and into the area of regulation, and have been working in occupational regulations for 15 years.

COMMISSIONER GORDON: Great.

MR. HIENDLMAYR: And, in fact, I have a previous association with Mr. Pizzorno when the

agency was involved in a sunrise occupational analysis process where we looked at whether occupations should be regulated by the state.

COMMISSIONER GORDON: Great. No, I appreciate that. I am trying to -- because it is -- as I said, it is such an interesting and challenging position. I think we are all really interested in what is going to unfold here. And you seem both very relaxed about and raring to go.

MR. HIENDLMAYR: Well, Commissioner, my job is really not much different than Mr. Leach's job as executive director of the Board of Medical Practice.

COMMISSIONER GORDON: Great.

The other question I have really relates to the previous panel and I wonder if you could address the concerns that -- you were here during the panel. What -- are there explicit, implicit safeguards for medicine that arises out of particular cultures, cultural practice or health care that arises out of particular cultures? Do you see that included in this act?

MR. HIENDLMAYR: Commissioner, I think that the act itself does not change any of the

existing law regarding the unlicensed practice of medicine. Let me say that first. I think the act recognizes the liberty right, the freedom that people have to engage in a livelihood and to practice skills and knowledge and use it to the good.

What the law does do is impose on every person certain responsibilities and duties regarding communication to the persons that they are going to provide alternative or complementary health care services to. And in that regard it does restrict a little bit of freedom. It does impose a duty and some requirements but there is no credentialing activity and if you practice safely and ethically and professional you will never come to our attention.

COMMISSIONER GORDON: What about the whole issue of diagnosis and treatment? How does the law handle that? I mean, if I am working within --

MR. HIENDLMAYR: Commissioner, I think the answer -- the simple answer is that the Medical Practice Act is still very much in effect and to the extent to which activity

constitutes the unlicensed practice of medicine it would be prosecuted by the Board of Medical Practice.

COMMISSIONER GORDON: See, I have a hard time understanding. It seems like there is a contradiction and the contradiction is if I am practicing -- you know, I practice within several different traditions. If I say you have a wind condition and I am going to treat it with thus and so, Qigong treatment or meditation, am I practicing medicine? I am not a doctor. Am I practicing medicine without a license?

MR. HIENDLMAYR: Well, Commissioner, I think that each situation is going to be evaluated on its facts and I think if it is a consumer's understanding that you are going to treat an infirmity and their expectations are not met, we will or may hear about it and investigate it.

At some point in time we may need to decide whose jurisdiction applies to the situation but I think that the basic issue is, is the patient harmed.

COMMISSIONER GORDON: Okay. Well, that is a different then.

MR. HIENDLMAYR: And then I think follow-up concerns and issues have to do with exploring the facts of the situation and whether or not there has been any misrepresentation of the services and the skill that would be applied to the consumer.

COMMISSIONER GORDON: Okay. But there -- do you understand what I am saying that there is a contradiction between the Medical Practices Act and this Act? At least as I see it because whatever -- if anybody comes to you for healing, there is some condition, whether you are saying they are possessed or it is a wind invasion or whatever it might be, there is going to be within the cultural frame of reference -- or you have this tight muscle, that is a diagnosis in itself, and I am going to give you a massage.

MR. HIENDLMAYR: Well, I think we can split hairs about, you know, what is a diagnosis, what is an assessment, what is an evaluation. And, yes, it has been acknowledged that the Medical Practice Act kind of covers the universe but it is also true that we have numerous health care specialties which have been created, defined, carved out of the Medical

Practices Act and I think that there is enough gray area here --

COMMISSIONER GORDON: Okay.

MR. HIENDLMAYR: -- in terms of what the Medical Practice Act covers and can be clearly applied to as a regulatory scheme and, you know, other areas which are much less clear that what we need are merely some professional and ethical standards that can be brought to bear until we can get to the point where we know what sorts of skill and education and competency based standards do apply.

COMMISSIONER GORDON: Okay.

Yes, you wanted to say something.

MS. BEYER: I just wanted to comment and of course the perspective of the people in the natural community is very different. Their philosophy is very different from that of the practice of medicine.

It is like most of these people do not see and are not interested in diagnosing diseases or "practicing medicine." For instance, the theories are so diverse, it is almost like medicine deals with the end state of a very long process and these other natural

therapies deal at the far end of the other -- the causation sort of thing and where medicine will diagnose a disease, these other therapies are not interested in the disease.

They are interested in what is the dynamics or the process in the individual that is making them feel uncomfortable instead of a disease.

Like, for instance, Ayurvedic medicine will give you a list of questions. Do you feel better at night or in the morning? Do you like hot liquids or cold liquids? Do you sleep with your feet out of the covers? And pretty soon they assess you, that you are a different balance in the veda bida kafa. Okay.

Nursing will do all sorts of assessment and will try to identify the pattern of the field.

Homeopathy will try to give you a lot of diverse questions about your total lifestyle, your attitudes, your fears, your habits, and they will try to determine and establish a defined vital force.

So they are totally different paradigms and it is almost impossible for you to overlap

them or expect them to intermesh so we do not feel that the natural health therapies are competing against medicine. They are just two different philosophies and they need to be handled differently, promoted differently and dealt with differently.

I do not know if that answers your question but I am glad to have --

COMMISSIONER GORDON: I hear what you are saying.

MS. BEYER: Okay.

COMMISSIONER GORDON: I am wondering -- yes?

MR. _____: Going back to your basic question as to whether or not you believe regulation really protects the public, that Institute of Medicine report that came out about six months ago that suggests that despite this massive regulation, certification, accreditation and oversight, we are not doing a very good job because we are killing about 100,000 people a year in our hospitals. Now it maybe suggested that if we did not have all that regulation we might kill 200,000 people a year in our hospitals but it is the equivalent of a jumbo

jet crash a day.

Others would suggest that because the system drives people into the two riskiest types of therapy, the prescription pad and the scalpel, that may be one of the responsibilities for a lack of protection and, in fact, overall we may have less mortality and morbidity if we had the type of open access that is being discussed here today.

(Applause.)

COMMISSIONER GORDON: I was also wondering, Mr. Leach, if the Medical Board feels comfortable with the kind of definition that is being articulated by the Department of Health?

MR. LEACH: Mr. Chair, when the bill was brought forward last session in its initial form the Medical Board actively opposed the legislation. However, by the time it was rewritten and certain amendments were attached the Medical Board withdrew its opposition.

COMMISSIONER JONAS: Really?

(Applause.)

COMMISSIONER JONAS: One of the things that we are trying to do is to see how the experience here can have relevance to the rest

of the country. So I am wondering how the Medical Board came around to seeing -- to a very different perspective.

MR. LEACH: The Medical Board's two main objections to the bill as first presented:

(1) If a physician, one of our licensees, was not holding him or herself out as a physician and practicing alternative modalities, they would no longer be within our jurisdiction. They would have fallen within the jurisdiction of the Department of Health.

COMMISSIONER GORDON: I am sorry. I did not understand. Can you say that again?

MR. LEACH: If a physician was practicing alternative modalities but was not holding him or herself out as a physician, rather than John Smith, MD, it was just John Smith down the hall, alternative and complementary healer, we would no longer have jurisdiction over that individual -- over the individual's medical license, and we found that to be problematic or the Board found that to be problematic. That provision was taken out or the Board was exempted from that particular provision. Excuse me, our licensees were

exempted.

The other main objection the Board had to the bill in its original form was that it allowed individuals to diagnose and treat medical conditions and when that -- when it was amended to exclude diagnosis -- plus there were some other small objections the Board had and they were changed and we withdrew our objection.

COMMISSIONER GORDON: So are you comfortable with people -- is the Board comfortable? I think my mic is going off. I do not know what that means.

Are you comfortable as a Board with people practicing within the context of cultural traditions? Because this was -- you were here when the people were speaking and they had a tremendous concern about what might happen and so I wanted to address that.

Is the Board generally comfortable with people working with people within their own tradition and, if not, they may or may not call it diagnosis but assessing them and working with them?

MR. LEACH: Mr. Chair, yes, the Board is generally comfortable. As I said, we are

charged with the responsibility of enforcing the Medical Practice Act. One of the provisions of the Medical Practice Act under practicing without a license is that an individual cannot undertake to diagnose and treat medical conditions. The Board acknowledges it is a very broad definition of the practice of medicine, however that is the law that we are charged to enforce. We have no choice.

The answer to that -- to the critics of the Medical Practice's Act definition is to go to the legislature and have the law changed but we have no choice in our approach to enforcement of that law.

COMMISSIONER GORDON: Okay.

COMMISSIONER JONAS: My sense is that actually the law removed this particular practice from your jurisdiction and, therefore, allowed the particular jurisdiction for the licensees that you are responsible for really to be unchanged and so, therefore, it did not really impact that -- your job in that sense of that particular population.

But it also did not necessarily address what we heard in the last panel, which was these

culturally derived practices because it still imposes particular regulations around a framework of whether you are diagnosing or not treating, which many of them did not.

Now there is an intermediate group obviously that we have heard from here that fall into a slightly different category.

MR. LEACH: Mr. Chair, members of the Commission, I do want to point out that the Medical Board's enforcement mechanism is entirely complaint driven. We do not actively go out into the community and try to identify individuals who are diagnosing. We have to receive a complaint before.

COMMISSIONER GORDON: A complaint from a patient or a complaint from --

MR. LEACH: From anywhere.

COMMISSIONER GORDON: I am sorry.

MR. LEACH: From anywhere.

COMMISSIONER GORDON: From anywhere.

COMMISSIONER JONAS: I am curious as to then how will a similar type of approach be taken for the unlicensed group? I noticed number of rules that have to be followed as well as disciplinary. The office apparently where

complaints come has various disciplinary actions. Is there going to be similar kind of complaint driven and, if so, who is going to be involved in enforcing the removal of the right to practice, which as I understand is really kind of the privilege that is being granted by this office.

MR. LEACH: Commissioners, the activity for investigation and enforcement is complaint driven and it would be the commissioner that initiates legal action to deprive the liberty right.

COMMISSIONER JONAS: And then who actually executes that? I mean, it is not a -- there is not a Board of Medical Practice regulation.

MR. LEACH: It is the Commissioner of Health.

COMMISSIONER JONAS: It is the Commissioner of Health then does that. And so you are going to have extra staff and that type of thing to execute these and oversee this process?

MR. LEACH: About one-and-a-half.

COMMISSIONER JONAS: One-and-a-half.

(Laughter.)

COMMISSIONER JONAS: You do not anticipate very much, huh?

MR. LEACH: Well, our experience and our history is that, you know, at some point we settle a lot of the issues that we have and we get the cooperation of the persons that we are dealing with and get a resolution that protects the public.

COMMISSIONER JONAS: Does the Commission -- is the Department of Health going to issue a certification of a right to practice of some type or it is assumed that people can do this as long as they have not been found to violate these rules?

MR. LEACH: We are issuing no credentials or no permits. The liberty right stays exactly where it is and --

COMMISSIONER JONAS: So only if it is investigated and found not to comply?

MR. LEACH: Only if there is an established violation would we restrict the liberty right.

COMMISSIONER JONAS: Okay.

COMMISSIONER GORDON: Thank you very

much.

We would very much like to have from all of you as the law goes into effect some kind of status report. It would be wonderful if you could do that. Just let us know how it goes.

MR. LEACH: The law requires that in two years the Commissioner of Health report to the legislature.

COMMISSIONER GORDON: No. I am wondering if we could get back to you, though, and find out just even after six months because we are going to be writing our report and just get your impression.

MR. LEACH: Okay.

COMMISSIONER GORDON: Okay. That would be wonderful.

And any of you, we welcome any of your thoughts as this goes into practice.

Thank you very much.

(Applause.)

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MINNESOTA LEGISLATION

MS. CHANG: Diane Miller, Representative Lynda Boudreau, Shirley Brekken, Stephen Bolles, Helen Healy and Jerri Johnson.

COMMISSIONER GORDON: Okay. I think this is -- can you turn that up a little?

The first speaker will be Diane Miller.

DIANE MILLER, JD

NATIONAL HEALTH FREEDOM COALITION

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

As you know, we have designed a new statute in Minnesota that protects individual rights to access unlicensed health care practitioners. I have an hour presentation prepared explaining the bill but I hope you invite me to give that to you some day.

For today I would like to ask you to review the law and remember that:

(1) Minnesota Statute 146A protects consumer access to unlicensed health care practitioners by allowing unlicensed practitioners to practice under certain conduct guidelines and mandating the use of a Client Bill of Rights.

(2) It is not an exclusive scope of practice bill like professional licensing statutes and it does not exclude anyone.

(3) It is a new model of law to address relationships and a free society.

Instead, today I would like to share with you key issues that invariably come up when I travel and meet with groups around the country discussing freedom.

Firstly and foremost, we must listen to the voice that is heralding the need for change. Listen and remember. Who is the voice? What is it saying. The collective voice of individuals has now become the wailing voice of survival. This voice is the heart and soul of our country. It is the voice of the people. Listen to the truth sayers.

Secondly, understand the root of the problem. The most common error I see in groups forming is that they solicit advice exclusively from health care practitioners and administrators rather than utilizing a broad range of health care experts able to speak to health care history, sociology, customs, economic structures, laws, regulations and

public policy and international impacts and more. It takes more than three minutes.

Third, develop groups with inclusive representation. Where are the greater numbers of diversity in this room today? There are many silent voices and spirits. Many resources with us today.

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

And, finally, address especially tough problems with everlasting compassion and creativity, developing special think tanks and utilizing special mediators, elders and problem solvers to help come to resolutions. No one said healing the community would be easy. Use the resources we have.

We must remember that in our democracy it is possible to find a glorious balance between the yearning of the individual to have free choice, autonomy and integrity in healing

and the responsibility of the community as government to protect its members from harm.

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Representative Lynda Boudreau?

REPRESENTATIVE LYNDA BOUDREAU

MINNESOTA HOUSE OF REPRESENTATIVES

REPRESENTATIVE BOUDREAU: Thank you.

As a legislator I recognize that the role of government in health care is to protect citizens from harm and at the same time protect citizen rights of individual choice and autonomy.

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

The existing Minnesota Statute 147.081 has an overly broad definition of the practice of medicine, which reads "Anyone who offers or

undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person" is practicing medicine without a license and is guilty of a crime.

Three tools that helped to guide legislative changes last year include:

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

Another tool: A 1998 study conducted by the Minnesota Department of Health, which was directed by the legislature in 1997, also provided recommendations regarding complementary and alternative therapies. That study evaluated the types of therapies available in the state, the existing regulation of such, consumer utilization and possible regulation concepts.

The third tool: A 1999 program

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

The Minnesota Complementary and Alternative Health Care Freedom of Access Act of 2000 passed last year, as you heard, in the House and Senate and was signed by Governor Ventura, it will become law in July of this year. This did not happen without extensive debate, vehement opposition from many representing traditional medical interests and the persistent support from consumer advocates.

(Applause.)

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Shirley Brekken?

SHIRLEY BREKKEN

EXECUTIVE DIRECTOR, MINNESOTA BOARD OF NURSING

MS. BREKKEN: Good afternoon.

The Minnesota Complementary and Alternative Health Freedom of Access Act provides for which practitioners will be able to practice as unlicensed complementary and alternative health care practitioners under the jurisdiction of the Department of Health.

The Minnesota Nurse Practice Act provides for practice as a licensed nurse under the jurisdiction of the Board of Nursing.

Neither law clearly provides for how a licensed nurse may practice complementary and alternative health care. This lack of legal clarity has contributed to confusion and concern for nurses who provide complementary and alternative health care.

The definition of complementary and alternative health care practices is not descriptive and explanatory but rather is an inclusive but not limited to list of practices that have usually been recognized to be outside

the mainstream of health care. The legal definition of nursing in the Nurse Practice Act does not include these complementary and alternative modalities.

Because the definition of nursing is a scope of practice definition, this lack of inclusion in the legal definitions of nursing and the lack of standardization for such practices in nursing education curricula and competence measurement mean complementary and alternative health care practices are not within the legally defined scope of nursing practice in Minnesota.

Two provisions in the Complementary Therapies Act further contribute to the confusion. The law defines an unlicensed complementary and alternative health care practitioner as a person who is not licensed or does not hold itself out to the public as licensed or registered by a health-related licensing board when engaging in that complementary or alternative practices.

The effect is that a nurse may practice as an unlicensed complementary therapies practitioner under the jurisdiction of the

Department of Health. However, if the individual who is also a nurse identifies one's self as a nurse, the individual is subject to the jurisdiction of the Board of Nursing. And, as described, the legal definition of nursing does not include the practice of complementary or alternative health care practices.

The Client's Bill of Rights requires the unlicensed complementary and alternative health care practitioner to divulge the degrees, training and experience or other qualifications the practitioner has to provide that complementary care. Does this require the unlicensed complementary or alternative practitioner to reveal education as a nurse? And if one identifies one's nursing education, is the effect that the individual is holding one's self out as a nurse? Nurses often ask these questions especially in relationship to how to identify themselves within their business.

A license to practice nursing provides to the public a confidence that the nurse has met education and competence requirements. Complementary and alternative health therapies

are not usually included in those expectations.

Many nurses who practice complementary and alternative health care posit that preparation and experience as a nurse enhances their ability to practice complementary or alternative practices.

The Board of Nursing is aware of the confusion and concerns of nurses who practice complementary and alternative therapies and is interested in working to integrate these modalities into the conventional health care system. The challenge of conventional regulation is to provide the consumer with clear and useful information regarding expectation of licensed nurses.

COMMISSIONER GORDON: Thank you.

Stephen Bolles?

STEPHEN BOLLES, DC, VP

NORTHWESTERN HEALTH SCIENCES UNIVERSITY

MR. BOLLES: Mr. Chairman, members of the Commission, I serve as vice-president for Institutional Advancement at Northwestern Health Sciences University. It is a small multi-program institution here in Minneapolis with professional training programs in chiropractic,