Oriental medicine, acupuncture, therapeutic massage, academic programs in undergraduate studies and a graduate program in integrative health and wellness.

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 all too often absent.

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, in this case mainstream medicine, to remember the need for sensitivity and respect in many instances. these forces play off 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: That 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.

Secondly, there must be federal-level support for examining the professional and historical cultures that have given rise to CAM practices, procedures and professions.

Thirdly, there must be federal-level legislative and funding support for the development of non-allopathic academic health centers.

And, fourth, my recommendation is there must be continued and expanded federal support through the NIH to conduct research which examines whole nonmedical health care cultures, practices, delivery methods and effectiveness by means that do not seek to extract and isolate modalities and procedures.

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.

COMMISSIONER GORDON: Thank you.

Helen Healy?

HELEN HEALY, ND

WELLSPRING NATUROPATHIC CLINIC

MS. HEALY: 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 NDs 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 that the Office of Unlicensed Complementary and Alternative Health Care Practice shall serve as 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 do not 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.

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 of 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" or "physician" alone or in combination with the word naturopath. If we do, it is ground 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 four-year program graduating competent and compassionate NDs.

Thank you.

COMMISSIONER GORDON: Thank you.

(Applause.)

COMMISSIONER GORDON: Jerri Johnson?

JERRI JOHNSON, BS IN NURSING
MINNESOTA NATURAL HEALTH COALITION

MS. JOHNSON: Thank you, Commissioners.

My name is Jerri Johnson. I am a homeopath and member of the Minnesota Homeopathic Association and the Minnesota Natural Health Coalition.

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 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 and regulated model, what richness might be lost in the process?

If we license a few isolated modalities in an attempt to promote natural health care, what will happen to the hundreds of other

modalities which still remain illegal to practice?

When I started studying this issue, I sincerely believed that licensure was the effective way for these modalities to become mainstream but then I started to think. Will we license Reiki, and then Qigong, Feldenkreis, homeopathy? How about aromatherapy, healing touch, Shiatsu, Gerson therapy, Ayurvedic, hydrotherapy, Jin Jin Jitsu, Tui Na, anthroposophy, colostrum therapy, Shen, the Hmong, African, Native American Shamans and healers? The list is endless.

How far will we go before we get weary leaving hundreds of spectacularly effective modalities in their current illegal status practicing medicine without a license and they will probably die out completely?

I believe that 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.

In Minnesota we said we must find a better way so that the people can have access to all of the healing modalities.

My recommendations for a broadly based and inclusive approach for unlicensed practitioners:

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

Avoid mandating a particular type 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..."

And for licensed practitioners:

Create the flexibility for them 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.

(Applause.)

DISCUSSION

COMMISSIONER GORDON: Thank you all. Questions?

COMMISSIONER LARSON: This is for Ms. Brekken.

What do you tell your nurses who -- now about the practice of nursing and also the practice of any kind of complementary and alternative medicine?

MS. BREKKEN: Commissioner, we respond to nurses and many of them are in this room that I have talked with on numerous occasions that if they practice -- what the law provides is that they practice alternative and complementary therapies as an unlicensed practitioner, they are subject to the jurisdiction of the Department of Health. If they practice nursing, they are subject to the jurisdiction of the Board of Nursing. And it does cause confusion because there are many instances in which nurses

-- nursing education has included many of the alternative practices through the years such as guided imagery, you know, focused breathing, you know, touch, any of those kinds of modalities.

What this law does is really cause confusion for those practitioners and trying to determine how do they inform their clients as to the kind of care that they are providing.

COMMISSIONER LARSON: Do you suggest as maybe perhaps Dr. Jonas had suggested that you have two different offices, you know, when you are practicing nursing with the same person and then --

MS. BREKKEN: What the board has attempted to do with the community of practitioners is to, you know -- to work with the practitioners and try to identify how a nurse may practice complementary and alternative therapies.

COMMISSIONER LARSON: So you still have not worked that out.

MS. BREKKEN: We have not worked that out.

COMMISSIONER LARSON: Okay. That is what I wanted clarity on. Because if you do in

the next few months, please let us know.

MS. BREKKEN: We will give it a try.

COMMISSIONER GORDON: Joe?

COMMISSIONER PIZZORNO: I have lots of questions but I will just start with just two.

The first one is to Dr. Healy. I know that in the late '90s you came very close to successful licensing. Can you tell us what happened? In addition, was there any restrictive language in that legislation that prohibited anybody else from using natural therapies like herbs and vitamins and things of that nature?

MS. HEALY: Well, briefly what happened was prior to my going for licensing again since I am not one of the people that started in 1909, I came in and started working on it in the '80s over and over again, but I was accused of practicing medicine without a license and there was wonderful support from the community and helped pull me through that, and since I was accused of practicing medicine without the license I said, "Well, let's go for it again. Go for the licensing."

So we were on a roll but the first thing

I did before I put pencil to paper was I grabbed the Montana law and there is a paragraph in the Montana law that says, "This bill in no way prohibits the use of..." and then it starts listing, you know, herbs, homeopathy, water, air, light, you know, et cetera, by anyone for any reason.

And I took that paragraph and I blew it up so big on my copier and ran off copies and handed it to many supporters, and said, "I want you to know that before I write another word this licensing bill is not going to restrict the use of natural therapeutics at all. This bill I am trying to write is just that I feel that the naturopaths need regulation for ourselves so we can practice as we are taught and some of the things that we are taught to do overlap with conventional medicine practices."

And, anyway, so to make a long story short, there was opposition when we, you know, hit the legislation and you could imagine it was disappointing.

COMMISSIONER PIZZORNO: The second question: Where did the opposition come from? I actually have a different question but can you

just say.

MS. HEALY: Okay. I will wait for the tomatoes.

(Laughter.)

MS. HEALY: Actually surprisingly, I guess, since you know, Robert Leach, it was like one of those switching things. Robert Leach and the Medical Board were first against me. I think as they became more educated about our education as naturopathic physicians, they softened a little bit and they were willing to have us go under their board the same way they do with the acupuncturists and the nutritionists.

But what happened was that many of my supporters, as you heard on the panel, they were afraid that if naturopaths got licensed that that one paragraph I told you about, that they were afraid that that was not really going to become true and that they thought that everyone was going to have to fulfill the standards of a naturopathic physician and they did not want that.

And as much as I could try to reassure them that was not going to happen, they did not

buy it and so they opposed us and also some money came in from out of state and there was a lot of other opposition when another law firm came in and did a whole lot of you know what.

Okay.

COMMISSIONER PIZZORNO: A quick question for -- maybe not a quick question to Diane Miller. The term "doctor" I think is an academic term that is granted by accredited institutions and yet I notice in the legislation that it says a person cannot call themselves a doctor. So I do not know understand how the state law can preempt an academic designation. Can you explain how that works?

MS. MILLER: That came towards the end of the legislative process in a compromise with the medical community but the concern was that when you add the word "doctor" to a healing art the consumer or the public thinks it is a medical doctor because that is the genre which they are used to. And so they just limited it to doctor when it is with a healing art. It does not prohibit the word "doctor" in general. It is just when it -- it is just when it is used with the therapeutic care.

COMMISSIONER PIZZORNO: Does the state have the right to do that? I mean, this is --

MS. MILLER: Oh, you are asking me -- I cannot advise you legally.

(Laughter.)

COMMISSIONER PIZZORNO: Well, it seems to me if this is an academic degree, why -- I do not see how the state can take an academic degree away from a person.

MS. MILLER: Well, I would just defer to getting a legal opinion about that. I mean, it is controversial obviously. I have a doctor of juris prudence but I think because the breadth of the case law with the ability of states individually the Federal Government cannot regulate the healing arts because there are state issues and the state case law is usually very broad in terms of regulating the health and welfare of their culture, and usually that has to do with doctors and so broad police power in that area.

So my guess is between those two, the giving of an academic credential versus the safety of the population, I would guess that the police power would win with the health care.

COMMISSIONER GORDON: Wayne?

COMMISSIONER JONAS: No.

COMMISSIONER GORDON: George?

COMMISSIONER DeVRIES: Thanks.

Dr. Bolles, Northwestern was unique as a chiropractic college in that it became a health science college and added acupuncture, Traditional Chinese medicine, massage therapy. How is that working and what are you seeing in terms of cross-training of students in other areas?

MR. BOLLES: Mr. Chairman, Commissioner DeVries, it is working very well. We have been increasing the enrollment of the acupuncture into our medicine institution, our massage program is also starting slowly but doing well, and our graduate program is -- we expect to receive final accreditation by our regional accreditor this fall and we have been matriculating students in the first five classes as part of that program.

We went into it not quite sure what levels of cross training would ultimately take place outside of integrating our school clinics. We have run seven outpatient public clinics

around the Twin City area. What we thought -- what we imagined ahead of time might be some efficiencies in the basic science and clinical science training have proven to not yet demonstrate themselves. In part, because of the way we already are block scheduling our chiropractic program. We run three trimesters a year.

Our school is 232,000 square feet and we are at 98 percent occupancy and we are so crowded that actually we had to start the acupuncture program in the evening, which is the way the previous institution before was assimilated around its programs. We are taking on some additional space and starting day programs.

We were challenged by some of the student cultural aspects and sort of rushed in when we should have waited more gingerly and we had to back up and honor the respect that we felt these cultures should be accorded and it is working out very well. So a year after -- a little bit a year and a quarter after we changed over, our feet are underneath us and we are moving ahead but I would say we are much more

congruent as an institution now than when we first changed over.

COMMISSIONER JONAS: Thank you.

Also, at Northwestern you have an integrated health care clinic, too.

MR. BOLLES: Yes, we do.

COMMISSIONER JONAS: Serving the community and how is that operating and is it successful?

MR. BOLLES: I did not hear Ms. Schmidt's testimony this morning and I understood she was going to speak about it but our Natural Care Center and the Woodwinds Health Campus in Woodbury, a southeastern suburb of the Twin Cities.

At this point I think we can modestly claim it as being extraordinarily successful. It is actually unique. It is not a biomedical model. It is a clinic of our university system. A doctor of chiropractic is the clinic director. We have -- our sentinel services are chiropractic, Oriental medicine, massage therapy, naturopathy, and we have a Premium Health and Wellness product store staffed by a master herbalist.

We spent an entire year before opening just developing relationships with the medical physicians of the Health East Primary Care Clinics. There are four of them on the floor right underneath us. And at this point 15 to 25 percent of our new patient referrals are coming from the MDs. A relatively modest figure but it is about 15 times what any other national data seemed to indicate.

We have exceeded -- we have built two financial projections, pessimistic and cataclysmic, and we are nine months into operation and we are exceeding our financial projections and we are actually in the black.

COMMISSIONER JONAS: Congratulations.

COMMISSIONER GORDON: I think it would be very helpful for us to have a kind of --

(Applause.)

COMMISSIONER GORDON: -- both of your operation -- just of the things that you mentioned, the way you operate, the relationship with the allopathic medical community, and also how it works financially. That would be very useful for us.

MR. BOLLES: I have a presentation I can

e-mail to your office.

COMMISSIONER GORDON: Wonderful. Thank you.

Wayne, did you have a question?

COMMISSIONER JONAS: Yes. I guess, I do not know. All right. A very simple question.

How many on the panel are happy with the Minnesota law as it is currently written?

(Laughter.)

COMMISSIONER JONAS: How many are not happy with it as it is currently written?

I should have asked this from the last panel, too.

There is -- let me see if I have this right. If you are an MD then it is okay because this is not our job, you are outside of the scope of practice. It does not impact the scope of practice. But if I am an MD practicing CAM modalities I cannot do that because I cannot do this dual office better, this dual mind that you talked about before.

If I am an RN I am very confused because I may be able to practice CAM modalities if I do a little extra paperwork for those because I have to document it and disclose and this type

of thing.

If I am an MD then I have a big problem because I am not licensed here yet and I am a naturopathic doctor already by my licensing, training, et cetera, and that is specifically excluded.

If I am a chiropractor, it is okay because I am not allowed to call myself a doctor in Minnesota anyway.

MR. _____: That is not true.

COMMISSIONER JONAS: Is that not true. Okay.

MR. _____: It is an academic degree so we can call ourselves doctors.

COMMISSIONER JONAS: So a physician. So then you would not be prosecuted by this.

MR. _____: The term "doctor" in Minnesota is not a protected title under the Medical Practice Act. The term "physician" is.

Now a doctor can be appended to a modifier of a professional degree such as doctor of chiropractic and under our scope of law that is allowed and we are limited to what we can call -- hold ourselves out to be as well. Part of the problem is under the law for the

Department of Health is that doctors of chiropractic fall under the purview of our state regulation board, the Board of Chiropractic Examiners, and we are specifically exempted from that legislation.

COMMISSIONER JONAS: Okay.

MR. _____: Unless we are doing practices that our board does not regulate in which case we would have the same -- we would have to operate under cover much as the nurses do.

COMMISSIONER JONAS: Okay. So the doctor title referring specifically to chiropractors were exempted from this law because of other regulations which allowed that. Very interesting. So there is an exception to that.

MS. _____: Four boards.

COMMISSIONER JONAS: Four boards.

MS. _____: Medicine, podiatry, chiropractic.

COMMISSIONER JONAS: Chiropractic.

MS. _____: And dentistry.

COMMISSIONER JONAS: And dentistry. Okay.

So if I am a lay homeopath or an herbalist or a massage therapist perhaps or spiritual healer then this is great. This gives me some place where I can go and practice legally. I know how to do it. I can -- there is professional standards. There is somebody that is overseeing me, et cetera. If I am a traditional healer so far I cannot figure out how this is relevant to me at all because it is not adequate to allow me to come out from under ground. Is this --

MR. _____: You got it.

COMMISSIONER JONAS: Okay. How does this -- and maybe you can help us figure out how this forwards integration?

(Laughter.)

COMMISSIONER GORDON: Please, yes.

MS. _____: Yes, I --

COMMISSIONER GORDON: We would like to hear every -- we are happy to hear everybody on this question.

MS. _____: I think one of the things that it does, at least it has done it -- I believe within the nursing community is it brings it out in the open and yet it puts out so

that you can start to identify what the issues are and at least try to work towards resolution of those issues. In the past the parties were at such extremes that there just really was no effort at trying to, as you said, identify all the things that you have and figure out is there a way to resolve them.

COMMISSIONER JONAS: So it has made it explicit.

COMMISSIONER GORDON: Thank you.

Let's hear from the other two speakers, please.

MS. _____: Commissioners, I would just like to say that this is a small step in the right direction to providing freedom of access to citizens and it was a tremendous battle and it is a small step, and we are not there yet.

(Applause.)

COMMISSIONER GORDON: Speaking of which, what else would you like to have happen?

MS. _____: I would like to not have it repealed and I would like to see that there are very little complaints when the report comes back to the legislature. I would like to

have it affirmed that these are not people that are causing harm to citizens and I think that would give impetus for some future changes.

COMMISSIONER GORDON: What other changes would you anticipate?

MS. _____: I would like to change the practice of medicine but that is going to take a huge --

(Laughter.)

COMMISSIONER JONAS: Can I just ask a --

COMMISSIONER GORDON: Diane?

MS. MILLER: I have a point of clarification. One of the things that happens with this bill is that people view it as a scope of practice bill and it is not. It is a jurisdiction bill. So this bill does not impact any licensed person who is holding themselves out to be a nurse, a chiropractor, a physical therapist. Anybody with a license that is holding themselves out and practicing their profession, it is as if our bill did not pass because it is not an exclusive. So it does not say you cannot do this. It does not say nurses cannot do the things on this list. It is just plain old giving jurisdiction to the Department

of Health in some situations.

So what happens is then if you are not -- if there were nurses in our natural health community that wanted the ability to practice outside of the scope of their standard of care and doctors and chiropractors, the people that want it -- people want to make that choice and the licensed portion of the bill did not pass to make that happen.

So what we did was we -- other than the four lobbies that went forward, the doctors and chiropractors, we carved out a space in our bill that the Department of Health could have jurisdiction if somebody was willing to take off their hat and not hold themselves out as a nurse so if they wanted to keep up their nursing license on the side but wanted to just be a homeopath for the rest of their life that there was a way for them to do that without -- so it does not exclude -- it is not taking away anything that was not there before. It is just adding a pocket for some people in the licensed profession. It is not a scope.

So it is -- it has to be talked through in terms of a jurisdiction bill and I know that

seems unusual.

COMMISSIONER JONAS: I am wondering has the legislature, the Minnesota legislature, considered doing some evaluation rather than just look at complaints but actually proactively examine the impact of this on -- so that it does not become sort of a licensing, you know, scope of practice issue, which it could easily become. By looking at what happens to actual patients, perhaps by doing focus groups or doing surveys or something like this to see if, in fact, no harm is coming and if the quality of care is adequate and this type of thing. That would require obviously separate effort in that regard.

MS. _____: Commissioner, that has not been done yet but I would expect as we go forward we will need to deal with the challenges that are presented to us. I am not sure what they will be. There could be some complaints that are frivolous that are causing us to be -- our attention to go there. I am very cautious. I am a skeptic. I do not trust some of the people I am working with so I mean I am a legislator. What can I tell you?

(Laughter.)

COMMISSIONER JONAS: I would hope and I completely lost where evidence-based medicine and science is in this but I would hope that some science or evaluation could be brought into the evaluation of this. I think it would be very helpful for the country as a whole and in terms of thinking about what can we from a federal level do, if anything. It is very -- when we talk about licensure issues and I agree this is not necessarily a licensure issue, this is an unlicensure issue, it is a state issue and it is not really -- the Federal Government does not have jurisdiction in that particular area.

So again I am at a bit of a loss as to what our role as a federal panel would be in terms of the licensure other than to watch it and follow it like you all are going to be doing.

MS. _____: Well, just try to keep in mind that citizens should be empowered and not professions.

(Applause.)

COMMISSIONER GORDON: Diane, and then I would like to give Jerri Johnson a chance

because I wanted to ask you a question.

MS. MILLER: I have a comment. I think it would be good to encourage states to evaluate on areas that you think are important on new models of all kinds that go forward. We are in a shift, a paradigm shift, and I think if you have areas that you want or believe you think are important areas, and just even like the research model paradigm is shifting and the questions that you ask are important. If there are questions of new regulatory legal models, if we can evaluate those or encourage us to evaluate those further than just what complaints come out. I think that is a great idea.

COMMISSIONER GORDON: Great. Thank you.

I have a very brief question for you, Diane. The issues related to already licensed professions, essentially they are unchanged -- are they unchanged at this point?

MS. MILLER: Already licensed professions that are practicing in their profession and holding themselves out as a licensed person are not affected by the new bill.

COMMISSIONER GORDON: So a physician who does herbal therapies --

MS. MILLER: Right.

COMMISSIONER GORDON: -- can continue to do that within that profession --

MS. MILLER: They are under the --

COMMISSIONER GORDON: -- or does acupuncture and does whatever.

MS. MILLER: The same nurses, the same with --

COMMISSIONER GORDON: Okay.

MS. MILLER: -- all licensed professions. If they are holding themselves out as --

COMMISSIONER GORDON: It is not as confusing as you thought, Wayne.

COMMISSIONER JONAS: Oh, okay.

MS. MILLER: Yes. It is just --

COMMISSIONER GORDON: What is that?

COMMISSIONER JONAS: If a medical board does not --

COMMISSIONER GORDON: Right, that is another issue.

COMMISSIONER JONAS: Okay.

MS. MILLER: Yes. It is just that --

let me give you an example. If you -- I do not want to advise you but if as a physician you take your hat off and go somewhere else and practice Qigong, you know, the definition is so broad you are not going to be charged with practicing medicine without a license. But if a chiropractic takes their hat off and goes and practices homeopathy somewhere, they could be charged with the practice of medicine without a license. Where under our bill the nurses will not be able to -- they are exempt from practicing medicine.

COMMISSIONER GORDON: That would not happen under your bill?

MS. MILLER: That would not happen for a nurse but it will happen for a chiropractor, podiatrist and dentist.

COMMISSIONER GORDON: Under this bill?

MS. MILLER: Yes. The -- in other words, the protection of this bill is not afforded to a licensed person if they want to take off their hat by those four boards.

COMMISSIONER GORDON: Jerri, it seems like from your testimony that you are not satisfied with this bill but I am not sure of

that. What are you looking for that you do not see at this point?

MS. JOHNSON: We had to make compromises as we went forward. One of the things that I was personally sad about was that Helen Healy and the other naturopaths will not be able to call themselves "physician or doctor" and that was forced upon us by our opposition.

When we initially designed this bill we wanted to make it possible for all of the people who are gifted in natural healing arts to practice, including the medical doctors, chiropractors, physical therapists, you know, and so we designed it that way. We said that for people who are licensed, they can practice the alternative healing arts provided that they give disclosure that this is outside of their standard of care and that it is not more harmful. And then for those people who are not licensed, they can practice provided they comply.

So we covered the whole gamut and that was our goal. In fighting the battle we lost the whole segment of licensed people and that is very sad. You know, we have dentists who are

mercury-free holistic dentists and need protection from their boards and that was very sad for us.

(Applause.)

COMMISSIONER GORDON: Linnea, you had a question.

This is the last and then we are going to stop for a moment.

COMMISSIONER LARSON: Yes. This is unrelated to licensing, credentialing, registration, et cetera. This is to you, Dr. Bolles, is it?

Why did you decide to spend one year in what you called building relationship and then what did that building relationship constitute? Did just little lunches here and there or was it a program plan thing to build collaboration?

MR. BOLLES: I had my people call their people.

(Laughter.)

COMMISSIONER LARSON: That is what I --

MR. BOLLES: Mr. Chairman, Commissioner Larson, what we did was we -- I had spent actually two years before we went into this studying what was going on nationally and taking

a look at what at that point were pretty exclusively to my awareness biomedical models of integrative care and was aware that from a business standpoint they were not working all that well. Many of them -- I will use this without meaning to sound too pejorative but had such substantial boutique start up funding that it really made it very misleading.

So I said -- and our Natural Care Center came out of collaborative discussions between two large medical systems, Health East and Children's, the University of Minnesota, with participation from Mary Jo Kreitzer, our own institution, and one other, and what we did was we developed the concept together.

And originally it was going to be that we managed the healthiest clinic and after we took a look at JACHO credentialing standards they were worried that the hospital opening might be slowed down so they sort of cleared their throat and said, "We would like to reconfigure the invitation. Do you mind being a tenant? We will give you prime real estate but we need you as a tenant." And that is how we ended up opening up the center.

It is a 4,500 square foot clinic. It is right off of the foyer of the hospital as you come in.

And so I said, "Let's -- we will do this." Because we know it is not a field of dreams. They do not just come if you build it. We had already seen the corpses of a few integrated care clinics litter the Twin Cities landscape. I said -- and it was part of my job in a different conception at that point. I said, "Let's just devote a lot of time to building relationships." So we did a lot of lunches, did a lot of breakfast.

We were fortunate to have some medical champions who were not initially very warm supporters of our efforts but because Woodwinds had established a guiding principle supporting complementary care so that all service units of the hospital had to demonstrate their adherence and support for it; there was an administrative context for it.

So there was a very broad administrative degree of support for this and we were fortunate to find medical champions that put us in front of the physician leadership and, quite frankly,

I am very comfortable and even somewhat determined to seek out people that were really dead set against having us there because we found that once we started dealing with the mythologies that it was, as it has all been said, England and America are two countries separated by a common language such, you know, medical doctors and nonallopathic providers often are as well.

So that is how we went about it.

COMMISSIONER GORDON: Okay. Thank you all.

We have 30 seconds. We have to -- we are really --

MS. _____: I would just like to comment that as I understand it our bill does cover the traditional cultural kinds of healers. If they want to have an exemption from the Medical Practices Act and they comply with the requirements of the bill, they will be under the jurisdiction of the Department of Health as I understand it.

COMMISSIONER GORDON: Okay. Is that your understanding, too, Diane, as a lawyer?

MS. MILLER: Yes.

COMMISSIONER GORDON: Yes. Okay. Great.

Thank you all very much. That is good to hear.

(Applause.)

COMMISSIONER GORDON: We are going to take a 15-minute break. We will return at 4:05 and begin the open sessions.

(Whereupon, a break was taken.)

* * * * *

OPEN SESSIONS

MS. CHANG: Susan Hageness, Pam Ahrens, Bob Barron, Kate Birch, Ann Richtman, and Tenby Owens, and also for the speakers -- if everyone can please take their seats. Thank you.

For the speakers we have been asked by the AV people if you could please approach your mics as close as I am right now because we are not able to hear you and get you taped for the transcription. Okay.

COMMISSIONER GORDON: Okay. We will begin now.

First is Susan Hageness. Thank you.

SUSAN HAGENESS, MA, RN

CHILDREN'S HOSPITALS AND CLINICS

MS. HAGENESS: Hi. Thank you for allowing me to address you today on the issues of access to delivery of pediatric complementary and integrative care.

Dr. Jonas, you asked why we do not have as much in peds out there in the world and it is because they do not have as big a voice and so I am here for that voice. Okay.

I also want to synthesize -- so I am deferring from what I gave you. I want to

synthesize today a little bit of what I have heard but I want to get in the components I think that are essential for an effective complementary and alternative medicine program in a health care setting and those components are fourfold.

Provision of clinical services and integrative therapies.

Education and information services, and Pam is going to talk about that.

Research in specific pediatric integrative therapies.

And then integration of cultural care practices.

And the only thing I want to say a little bit differently from what I have heard here today is I think one of the failures of the current CAM delivery system has been the segregating of CAM services into stand alone clinics. What we have done at Children's is from the get go incorporated it into both inpatient and outpatient approach. And so staff has seen it being delivered. They have learned about it. They have participated in it themselves and they have been referred to it.

The part about the research, the information piece, it is pretty self-explanatory. I guess I want to take my time a little bit to talk about the law that we were just talking about.

I am a nurse and I do not like the law. I was instrumental in -- well, I was not instrumental. I started in the beginning of the Minnesota Natural Health Coalition meetings and I liked what I heard but it is very concerning to me as a nurse who works in a health care setting where most nurses work and as a director of a program of an integrative clinic or health care program that as a licensed practitioner I cannot utilize my nurse, my nurse credential, and also my holistic or my alternative complementary modalities.

And so for me and for me as a director it is going to be harder for us to practice or to get providers in a health care setting that practice CAM services and not have them take their hat off as a nurse or as a physician or as a psychiatrist or as a psychologist and that is the concern I have with the bill.

I cannot in my 25 years of nursing

divorce that paradigm from myself. I cannot take that hat off. It is just who I am right now and so to take a hat off as a nurse to be a healing touch practitioner is basically impossible for me to do.

So in closing I just want to say the four components that I think are absolutely imperative for an integrative medicine program is delivery of clinical services, education information, research and integration of cultural care practices.

Thank you.

COMMISSIONER GORDON: Thank you.

Pamela Ahrens?

PAMELA AHRENS, MA

LIBRARY SCIENCE

CHILDREN'S HOSPITALS AND CLINICS

MS. AHRENS: Well, I am not going to talk about the law. I am a family information specialist and medical librarian with Children's Integrative Medicine and I am addressing the delivery of reliable and useful CAM information to health professionals and the public.

We know that the public has immediate direct access to health information medicine and

medical products online and they readily use whatever they find with their children. Over 70 percent of Minnesotans have access to the internet, over half of all adult internet users are searching for health information, and the top ten subjects that are searched include children's health and CAM.

In our clinics at Children's, 52 percent of the surveyed patients' families already use CAM therapies with their children, 49 percent of a specific survey group want CAM information provided through Children's, and the top five subject areas wanted are herbals, homeopathy, acupuncture/acupressure, aromatherapy and megavitamins.

My integrative medicine role is to facilitate the sharing of quality CAM information with health professionals and patients' families throughout the patient care process. On a daily basis, I am asked for information on CAM clinical trials, dosing, adverse effects or interactions, treatment guidelines or options, herbs, vitamins, supplements, immune boosters and other CAM products and therapies specific to children.

Examples of these requests are:

A pharmacist with an ICU patient whose parent wants to mega-dose the child with an immune booster supplement.

A mom who wants to know about holistic therapies for colic because nothing else is working.

An ER manager who needs to know what might be in a five-powders mixture that was fed to a comatose patient.

A parent and pediatrician who want information on a fat reducing product for a depressed adolescent.

A surgery team working with a mom who wants to use magnet therapy pre and post-op.

A non-English speaking family who wants information on ADHD because of their child.

A grandparent of an inpatient who wants to give aloe vera juice to her grandchild.

The millions of health-related information sources that the public accesses everyday cannot be ignored by providers who are often put into a position that is just having to react, even though it is extremely time-consuming to quality-filter that kind of

information because health consumers are readily buying and using unconventional products or therapies for themselves and for their children based on whatever information sources they access.

Physicians and other health professionals expect to find the same kind of information support that is out there for mainstream medicine, and are accustomed to the quick Medline-type retrieval of applicable research data, reviewed literature and protocols, and drug/product/treatment evaluation, but this is still very limited in CAM and especially pediatric CAM.

I, as an information professional, who routinely searches a vast number of databases, web sites, print and nonprint materials, and evaluate for criteria-based CAM information still struggle with the critical review of difficult information or produce sources, background checking and experiential data, or trying to uncover what might apply to children.

Health professionals at Children's and elsewhere need to get actively involved in quality-filtering and offering reliable

pediatric CAM web information and materials because families are asking for it.

For health professionals and consumers alike, help is needed in providing access to tools, training and support for evaluating information on health resources and experts, therapies and techniques, produces and manufacturers, and health on the net, and the pediatric world needs more evidence-based information and research on CAM for kids.

COMMISSIONER GORDON: Okay. Thank you. Bob Barron?

BOB BARRON, RN, ADN

WELLNESS EDUCATORS

MR. BARRON: Thank you for the opportunity.

Today I wish to speak to you about two subjects related to the topics under discussion. The first being the necessity of educating health care professionals in the recognition --

MS. CHANG: Would you come closer to your mic, please?

MR. BARRON: I am sorry.

MS. CHANG: Closer to your mic.

MR. BARRON: Should I start over?

MS. CHANG: No.

MR. BARRON: Okay. I wish to speak to you about two subjects related to the topics under discussion. The first being the necessity of educating health care professionals in the recognition of complementary and alternative medical practices. And the second, in looking at those same practices as a means of helping to alleviate the rising prescription drug costs for the elderly in our country.

My background in these subjects includes over 30 years of experience in using complementary and alternative medicine and over 12 years experience as a registered nurse in settings that include hospitals and home care.

Whatever your stance on the use of complementary and alternative medicines, there can be no doubt that the American public is spending millions of dollars yearly on them. During the last half of the 1990s I began to see an increasing number of the patients I encountered in their homes and in hospitals using CAM products that included herbal and homeopathic preparations, and nutritional supplements, among others.

In many instances patients concealed their use for fear of being ridiculed or interfered with by their care givers. Only by building trust between us were some patients finally comfortable enough to openly discuss their own involvement in CAM. During these discussions I often found that the patient made his or her choices based on inadequate or erroneous information. A very few people were well informed and understood the possible interactions between CAM and the more conventional treatments they were receiving. Most were not.

At the same time, the professional care givers charged with advocating for and protecting those patients were usually even less informed. Reasons for that include a lack of exposure and information, their own biases, and a lack of appreciation for how thoroughly CAM has permeated our society.

If we as health care professionals are to continue to deserve the trust and responsibilities to educate and protect that come with our role, we must become more informed about CAM practices now.

Moving to the subject of prescription medicines:

Studies released this week show that the cost of prescription drugs is the fastest rising portion of health care costs in our country. The elderly are among the largest consumers of these drugs and the hardest hit by their rapidly rising cost. Perhaps there will be some solutions found in economic and political maneuvering but such huge economic interests will be difficult to sway.

I recommend that we look to the many CAM practices available that would help any number of the ills the elderly are prone to and do so inexpensively and safely. I would especially promote the use of herbal and homeopathic remedies. An herbal diuretic prescribed for hypertension, for instance, may provide effective relief for just pennies rather than its more expensive counterpart.

To counter the claim that many of these remedies are unproven, it is easy to point to the many that are using any measure of science found in this country or in Europe.

If we had the will to do so we could

offer these affordable alternatives to our elderly population soon.

COMMISSIONER GORDON: Thank you.

Kate Birch?

KATE BIRCH, AS, RS Hom(NA), CCH, CMT

MINNESOTA HOMEOPATHIC ASSOCIATION

MS. BIRCH: Hi. I am going to talk about access to complementary and alternative information within the public educational system.

My understanding of --

COMMISSIONER GORDON: Come a little closer to the mic, please.

MS. BIRCH: My understanding is that the public has been limited to the access to CAM practices through these educational systems. The absence of curriculums designed to embrace CAM healing concepts limits our exposure to the possibilities in our own health choices. Our educational system is based on a reductionistic and mechanistic view of life. Furthermore, as there is a separation of church from state, this education system negates any understanding into the development of the human spirit. Tragically this mechanistic view of the world has been

fully developed into the existing medical model.

I will just say the first point here that from allopathic perspective most disease processes are viewed as mechanistic and physiological phenomena in the body.

And continue on to say that at this moment healing modalities are becoming more and more wide spread but the biggest limit for the consumer to them is education. Superstition, fear, ignorance and naivete rooted in the public education system about concepts having to do with spirituality, energetic understandings about life, or the true nature of our internal healing mechanism is limiting the public's right to the healing modalities that respect them as an integration of mind, body and spirit.

Contrary to conventional medical practices, most CAM practices operate under the following principles: And I will just read the first one I have here.

That is that the dynamic force that regulates health and disease is a piece of most CAM practices.

One only has to look at the crisis within the public education system to see there

is something inherently missing in an education system that denies vitalistic principles and sees people as mere protoplasm and negates any spiritual recognition of the individuals that get churned through the system. The increased occurrence of hyperactivity, ADD, violent and abusive behavior, marginalized academic and social skills, apathy, indifference, alienation and defiance, which are all common mental and emotional disorders in school age children mark the expression of an individual who's soul and character has not been recognized in their educational environment.

Remedying the educational system to incorporate some of the following solutions will have an effect of not only exposing the populace to CAM theories but would also be therapeutic in itself and reduce the need for palliative conventional medical treatment.

With this understanding, I offer some solutions:

Education at the primary, high school and collegiate level to include:

(1) Theory behind vitalism and healing.

(2) That the history of medicine be

reviewed in encyclopedias and amended to include more comprehensive and unbiased material on the great physicians or trends of thought with regards to healing practices that have otherwise been omitted, disregarded or disparaged as they offer ideas or conclusions contrary to allopathic medical practices.

There are many examples here.

(3) Design curriculums where concepts of mind, body and spirit are discussed and incorporated into learning strategies.

(4) Have courses open as to metaphysical science and practices, meditation and hands on healing practices.

(5) Explore and apply principles for anthroposophical education in the public school system.

COMMISSIONER GORDON: Okay.

MS. BIRCH: Thank you.

COMMISSIONER GORDON: Thank you.

Ann Richtman?

ANN RICHTMAN, JD

NORTHLAND NATURAL HEALTH RESOURCES, INC.

MS. RICHTMAN: My name is Ann Richtman. I am an attorney. I was a legal consultant in

the drafting of the bill but I am also very much involved in consumer education.

You have my written remarks. I am going to, I think, skip the first and come back to that if there is time and go to the second.

The second is about informed choice. The third is about informed consent, which we know of in a legal context.

And the recommendation that I have is based on the fact that I have read all of the written testimony that is available of your proceedings to this point in time and that has been really informative to me. And with that as a backdrop, I make these remarks on informed choice and informed consent.

As I read through that testimony, I asked myself what is the key issue here and how is it being addressed. To quote Harris Coulter, "Therapeutic doctrines have important economic aspects. People are sick and tired and increasingly they are more sick and tired."

In our region, which is Northern Minnesota and Wisconsin, revenues from the medical services industry are second only to iron ore and we will see that change very

quickly. In the nation, they are the largest sector.

Our local hospitals have an advertising budget that is unrivaled only by the pharmaceutical companies. Between them there is a constant and pervasive multi-level marketing of acute care services and prescription medications in our community. More and more packaged as news stories and public service announcements.

In America we have an insidious enculturation process from industry and governmental policies that normalizes an expectation of pathological outcome and compartmentalizes self-care as a programmatic option. How will the medicalization of our society be addressed in your report? Will you make available to us not only the testimony that has gone before you but also the accompanying written documentation and research provided to you so that we can better inform the public of the wealth of information that you are reviewing and so that we can make an informed response to your recommendations.

Secondly, informed consent. You are

aware that the doctrine of information consent springs from tort law, although there are those who see its importance in contractual application also. The U.S. Supreme Court has told us that we have a constitutional right to refuse treatment but it has also told us that government may substitute its judgment for our's when it comes to having access to treatment that we think most suitable to our individual health needs.

Our interests are further compromised by a statutory or judicial requirement that medical doctors advise their patients of alternative treatments -- this is the language -- but that those are not in any way inclusive of those alternatives known to you, known to us and known to many others outside the narrow confines of conventional medicine.

Is patient consent truly informed without disclosure of documented beneficial alternatives?

So again I would like to ask that all of the information that you get be made available to us so that the money and the effort and the energy that is going into your process can then

be passed on and perhaps we can see some changes in these other areas.

(Applause.)

COMMISSIONER GORDON: Thank you very much.

Tenby Owens?

TENBY OWENS

MASTER OF PULSE DIAGNOSIS

ST. LUKE'S CENTER FOR HOLISTIC HEALTH CARE

MS. OWENS: Thank you.

I am going to talk about data collection as a tool to create some validation between the interface of contemporary Chinese pulse diagnosis and allopathic medicine.

I have been a student with Dr. Leon Hammer for more than five years. He is a retired psychiatrist. In the course of his career he shifted away from his allopathic training to address his patients' ailments to methods based on Chinese medical physiology and practice, acupuncture and herbal medicine. A genesis of his lifelong exploration has been his development of what is now known as contemporary Chinese pulse diagnosis.

This is a specialized method of pulse

taking that is not taught in Oriental medical and acupuncture training programs. I am one of a group of practitioners who are faithful to this diagnostic method used for developing treatments for my patients. I am an herbalist. Others who use this method are practicing acupuncturists. Robert Heffron, MD, has been teaching this method to a handful of medical physicians, most of who work in Europe. This system lends itself to an apprenticeship method of teaching and learning so we study with Dr. Hammer twice a year to refine our pulse taking and interpretation skills and share our experiences on an ongoing basis.

It has become clear in this five year period that this inexpensive and noninvasive diagnostic method shares a fascinating and important interface with allopathic medicine, namely that all of us are finding what are undiagnosed significant health problems of patients who have come to us for services.

Some examples of this include undiagnosed diabetes, cancers, heart disease, hepatitis, duodenal ulcers, and brain abnormalities such as strokes. We are seeing

the correlations between our pulse findings and Western diagnoses because our findings are later confirmed by relevant allopathic tests.

We have concluded that it is important for us to take a first step in compiling our findings; that is creating a database so that we are systematically documenting these occurrences. The importance of this systematic collection is to demonstrate that a finding of mine is not an isolated event or for that matter of any one of us who happens to be using this practice.

Our belief is that we can later access this data so as to create a body of knowledge that correlates pulse findings with Western disease diagnoses in such a way that it will be meaningful to the allopathic medical community.

Research monies are not readily available to practitioners and schools of thought that are not already a part of the mainstream of health care. Understanding the benefit of a diagnostic method such as contemporary Chinese pulse diagnosis is not going to happen in an environment of skeptics such as mainstream medicine. Rather it will

grow out of the community of practitioners who use it and understand its importance and who are then able to bring it to that skeptical community in a systematic way.

We ask that you recognize this and recommend widening the scope of how funds are made available to practitioners of so-called alternative medicine.

Thank you.

DISCUSSION

COMMISSIONER GORDON: Thank you.

Questions?

George?

COMMISSIONER DeVRIES: I will pass for a moment.

COMMISSIONER GORDON: Okay.

Wayne?

COMMISSIONER JONAS: One quick question for Ms. Owens.

You are in the process now of trying to verify -- in other words, look for correlations of this process with standard diagnostic methods? You say you can diagnose diabetes early, for example. Has that been -- have you looked at that? Do you know what the accuracy

of that is?

MS. OWENS: I do not think that is exactly what I said and I do not -- I would -- what I described was instances where we are finding cases where people have a health condition, a full-fledged health condition such as diabetes, and their physician has not picked that up for some reason or another.

COMMISSIONER JONAS: That is not the same as being able to detect diabetes?

MS. OWENS: It is not necessarily early stage diabetes. That was the phrase you used.

COMMISSIONER JONAS: Oh. It can be actual flagrant diabetes.

MS. OWENS: It can be actual diabetes.

COMMISSIONER JONAS: Okay. So what is the accuracy of that?

MS. OWENS: Well, my point is --

COMMISSIONER JONAS: That is even easier.

MS. OWENS: That is a good question because my point is it has only been in the last couple of years because there are a number of us who are doing this particular pulse system and because we get together on a regular basis, we

have had the opportunity to begin sharing our case notes that cover, you know, the six months before we get together for a meeting and we are starting to notice, and we have started to notice that there clearly are patterns to -- we know the pulse pattern for diabetes, for example, and we are noticing not that we notice that it is diabetes but that we are picking up things that you would hope that physicians would.

So -- and that is very important to us, that we can provide that information to a physician that he is missing something if you know what I mean.

COMMISSIONER JONAS: So there is a pattern that correlates with diabetes.

MS. OWENS: Yes.

COMMISSIONER JONAS: That you should be able to take a group of diabetic patients, look at the pulse pattern, look at the diabetes, see what the correlation is.

MS. OWENS: Yes.

COMMISSIONER JONAS: And see what the accuracy of that is?

MS. OWENS: Yes, you should.

COMMISSIONER JONAS: Yes, okay. That would be very interesting. I would think that the national center would be willing to fund a study if it was properly executed and there are ways to do that. If any of your group is interested I can refer them to the individual --

MS. OWENS: I think, too, there is a broader issue that I am describing, which is there are lots of pulse qualities that correspond with lots of things. You know, if someone happens to have an interest in diabetes, that is well and good. It kind of misses a bigger picture, which is this is a tool that has tremendous potential for augmenting what doctors do diagnostically, you know.

COMMISSIONER JONAS: Right.

MS. OWENS: And it has -- not simply about diabetes but it has a lot of application.

COMMISSIONER JONAS: Right. I am concerned a little bit about these systems and kind of what I consider premature statements about their ability to detect things because there are a number of -- I am not picking on you. I do not know your system actually. It is the first time I have actually heard of it but

there are many, many systems that involve early or even established diagnostic tests that when actually tested do not correlate with what the practitioners think they correlate with and yet they are used to communicate to the patient that they have a disease and, therefore, they need a treatment of some type, and they may not use those terms in Minnesota now but in any case that is the implication. And the result is the fabrication of illness, you see, which is in itself risky and this is not confined to complementary medicine.

We did this in conventional medicine and continue to do it in conventional medicine but are learning that there are ways to try to get around this and I just want to make a general statement that this is part of why good research is important in diagnostic areas and that it is very important that those studies be done before one implies that one can identify an illness of some type because a lot of times it turns out not to be the case.

I did have a question and that has to do with the information. Do you have a lot of requests for specific complementary medicine

information in your center? I mean, do you -- 52 percent of people are using it. Are they aware that you provide services, for example, to them?

MS. OWENS: That was the incentive for the components of our program. We wanted to make sure that the assessment of information need was part of intake, was part of assessment, was part of treatment, and was part of evaluation. And to be able to be a part of facilitating physicians, families, community practitioners, anyone who is looking for applicable pediatric CAM information for a given situation that we have a way of offering that kind of service.

COMMISSIONER JONAS: Has there been a big demand for that?

MS. OWENS: Yes.

COMMISSIONER JONAS: I mean, do you have -- how many people do you have providing and working on that?

MS. OWENS: We are just in the process of loading into a database all of our client information but on an average day I would say two or three requests.

COMMISSIONER JONAS: Two or three requests. And then are you providing information where they can access some of that themselves and get information in a way that communicates to them what the issues are?

MS. OWENS: Yes. And I am not quite sure what you are getting at. We have collections of materials that we are putting together. We have fact sheet information that we are putting together based on research that we are in the process of doing as well as responding to specific information requests that families may have to explore what options that are out there that might be valuable to them or useful to them.

COMMISSIONER JONAS: I think this would be an essential service not only for the patients but also for the physicians who when they begin to ask --

MS. OWENS: It is.

COMMISSIONER JONAS: -- their patients what they are using and find out they are not quite sure what the implications are.

MS. OWENS: Right. Typical, you know, I have a chemo patient and the parent is giving

him a mushroom and I do not know anything about this mushroom.

COMMISSIONER JONAS: Right. Very, very good. That is very important. I think we are having a session on information systems later and it might be useful to get details about actually how you go about doing this and putting the information together.

COMMISSIONER LARSON: He asked my questions.

COMMISSIONER GORDON: Okay. Ann Richtman, I wanted to respond to your request for the information. We have on our website all the transcripts of all the meetings -- although -- do we have all the transcripts of all the town halls as well or summaries of some of the town halls?

MS. CHANG: No, they are actual transcripts.

COMMISSIONER GORDON: We have -- so we have transcripts of every sort of public meeting that we have had. We have also been sent thousands, maybe tens of thousands of pages of material. The way to access that -- because we do not have the resources to put everything --

make everything available and the way to access that is through Freedom of Information Act. There is no other way that we can do it and to ask for specific things that you have a particular interest in and we try to respond to that.

It is an --

MS. RICHTMAN: That is the --

COMMISSIONER GORDON: I am sorry.

MS. RICHTMAN: That is the only way you can make it available?

COMMISSIONER GORDON: There is no -- that is -- it is a request. I mean, that is the request, yes. Because there is such a huge amount of material and we do not have any -- we do not have the resources to catalogue everything and make it available and it is a major -- you know, let's say there are 10,000 pages around. Now what has happened is that we have -- we sort of go through it. We look at it.

We look at -- you know, somebody may send us 300 pages that are not particularly relevant to the question that we asked so we try to look at what is relevant to the questions

that we are asking and then different staff members look at it and try to use it as background material.

MS. RICHTMAN: The sort of thing I am referring to is that you had -- and I forget his name now but a person come in and make reference to 193 studies on how guided imagery and other techniques were useful in facilitating healing and someone asked if he would make those available.

COMMISSIONER GORDON: Right.

MS. RICHTMAN: And he said yes, he would.

COMMISSIONER GORDON: Right.

MS. RICHTMAN: So, I mean, that is really information I think that is important for us without having to go out and duplicate it.

COMMISSIONER GORDON: Right. Then the way would be to say that -- to make a request for the information provided by that person. Every time we ask for information that is in the transcripts that are publicly available.

MS. RICHTMAN: Okay.

COMMISSIONER GORDON: So let's say, you know, we asked you for information about the

law, you send it to us, somebody is going to see that a commissioner asked Ms. Richtman for information, and they will read that and they will say, "Oh, if I want that then I am going to --"

MS. RICHTMAN: So I am limited to what I can identify from the testimony.

COMMISSIONER GORDON: That is sort of the way it has to be, yes.

MS. CHANG: I am sorry. You are not limited. You can ask for whatever you want but -- and we -- and just a clarification. We will catalogue. We are cataloguing everything.

MS. RICHTMAN: Okay.

MS. CHANG: We are a little behind but we are cataloguing everything.

MS. RICHTMAN: That is helpful.

MS. CHANG: So that will be helpful.

COMMISSIONER GORDON: Yes. But it is -- but I think that whatever you ask for is going to take some time to get.

MS. RICHTMAN: Right.

COMMISSIONER GORDON: It is not -- there is no withholding. It is just coping.

(Laughter.)

COMMISSIONER GORDON: Other questions?

Joe, Linnea?

Okay. I -- Yes, George? Sorry.

COMMISSIONER DeVRIES: I have a question.

Ms. Hageness, just regarding Children's hospital, you talk about, you know, interest in CAM, use of CAM, help us a little bit specifically with Children's hospital, is it delivering CAM services? Do you have chiropractors, acupuncturists, other, you know, CAM clinicians and medical physicians in integrated medicine actually providing services at Children's hospital? How are you -- how or if actually delivering services within Children's hospital?

MS. HAGENESS: Yes. That is one of the important components. We are delivering. We do not have chiropractic. We have massage therapy, infant massage, healing touch, clinical aromatherapy, guided imagery, biofeedback. What did I forget?

MS. _____: Hypnosis.

MS. HAGENESS: Hypnosis, yes. And we do it both inpatient and outpatient.

COMMISSIONER DeVRIES: Okay.

MS. HAGENESS: So we will get an order from -- often times it is in the cancer population.

COMMISSIONER DeVRIES: Sure.

MS. HAGENESS: For a massage or for healing touch or for aromatherapy.

COMMISSIONER DeVRIES: Do you have a sense what percentage, just roughly, of your patients are receiving CAM services? Five percent, 50 percent, 75 percent, within the -- through Children's Hospital?

MS. HAGENESS: No, I do not right now.

COMMISSIONER DeVRIES: Just roughly. Okay. Thank you.

COMMISSIONER GORDON: I had two other thoughts. One is on this information issue. I think that what is going to come out of our next hearing pretty clearly and it has already come out in many of the town halls is a need for a central federal repository for information. Our information does not necessarily follow -- it is not systematic.

And I think that although you are welcome to it, the real need is that we have

discovered and heard about is for really systematic and easy access to all this information, and that is what we are hoping to -- that kind of recommendation is pretty clearly emerging from everything that we have heard and I have a feeling that it will only become stronger after our information hearing.

MS. _____: One thing that is important about it, whether you intend it or not, is the fact that you give it legitimacy. So that, I think, is really important for us particularly when we are dealing with multilevel mass marketing that we can say, you know, either this information came to the White House Commission or it came out of the White House Commission, and then, you know, whether it is the local TV station or the newspapers or doctors or whatever, people, I think, take closer look at it because it was important enough to come to you and you are --

COMMISSIONER GORDON: The problem there -- I do not -- I think it is important not to misrepresent it --

MS. _____: Right.

COMMISSIONER GORDON: -- anybody can

send us anything.

MS. _____: I know that.

COMMISSIONER GORDON: So we -- just because we receive it, does not mean that we validated it in any way so that is important as well.

One of the things that we will do when we do our -- not so much in the interim report, which is really going to be a series of recommendations with brief introduction but in our final report it will be very heavily referenced so that all that we have drawn on to make the recommendations, all those -- we are going to make sure that all those references will be there and that report should be available. It will be presented to the President in March 2002 and, hopefully, within a few months after that, one hopes, it will be available to -- widely available and hopefully inexpensively available as well.

One other thing, at the risk of revisiting this whole licensure question, and the law, I cannot for the life of me figure out why you would not be able to continue doing the practice as you have been doing for many years

as a nurse, therapeutic touch or relaxation therapies or imagery. I do not see how the licensure law can in any way get -- I mean, the new -- it is not licensure law but the Freedom Act can get in the way of that.

MS. _____: Well, the way I understand it is if I hold myself out as a nurse, I am accountable to the Board of Nursing and right now the Minnesota Board of Nursing does not have a statement that talks about what holistic practice is or complementary alternative medicine practice is for a nurse.

COMMISSIONER GORDON: Right.

MS. _____: So the fact that I practice healing touch as a nurse, and hold myself out as a nurse, healing touch practitioner, does not -- I am not covered under this new bill or this new law.

COMMISSIONER GORDON: Right. But you were not covered before either.

MS. _____: That is correct.

COMMISSIONER GORDON: Okay.

MS. _____: But it is out there in the open now and we are seeing how more and more facilities are integrating complementary and

alternative medicine so the fact that it is out there -- it is concerning for me as a director of a program, too, who works in a hospital as to how to -- you know, what do you do there? You know, do you say to a nurse you cannot have RN on your card or --

COMMISSIONER GORDON: I do not see why that would apply because it has been part of your scope of practice before and it continues -- or not part of your scope of practice.

MS. _____: It is not --

COMMISSIONER GORDON: So it was never part of your scope practice.

MS. _____: It is not.

COMMISSIONER GORDON: So you were always vulnerable. Okay.

MR. _____: May I also add a comment on that, is I called the Board of Nursing and talked to a legal representative and said, "Can I advertise myself as an RN in addition to my practice in the Bach flower therapies and she said, "No."

Okay. The concern I have about that is I had an experience once where a client came to see me for a Bach flower therapy and using my RN

assessment I determined that this patient had sepsis and I said, "You do not need to see me. You need to get in a cab and get down to the emergency room."

So by not allowing the public to choose someone with those assessment skills, we are depriving them of one extra layer of protection and that is my concern about this bill.

COMMISSIONER JONAS: Well, doesn't it make sense for -- to begin to expand the scope of practice for nurses or for all the professions?

MS. _____: That is the issue.

MS. _____: Oh, absolutely.

(Laughter.)

COMMISSIONER JONAS: And, of course, the flip side of that, if I am now going to a -- and I will pick on homeopathy because I know it the best, if I am going to a homeopath and they say, "Oh, you are just having an aggravation," and they have sepsis but the individual fails to recognize that they have sepsis, then they are not delivering a toxic therapy but on the other hand they do not have the clinical skills to make a judgment about something that could be

quite adverse consequences. And this again is one of my major concerns about the whole kind of freedom of scope of practice for unlicensed as to what standards are there for addressing number "Y", which is failure to refer to a doctor when appropriate. I do not know if that has been discussed.

COMMISSIONER GORDON: We are going not have to stop in 12 seconds. Do you have something in 12 seconds?

MS. _____: The concerns that you have, Dr. Jonas, are addressed in case law throughout this country and they may vary from jurisdiction to jurisdiction. So, for instance, in Wisconsin the courts may have decided that it is not within the scope of practice for a chiropractic to make a medical diagnoses and, therefore, he is not falling below the standard of care if X happens to the patient.

So there are other ways of determining what is the scope of practice and what is the standard of care for a health provider without it meeting the same standard that a medical doctor would.

And I would also add that what is good

for the goose is good for the gander. Let's look at the extent to which medical doctors are unable to diagnose. Let's be honest about that, too.

(Applause.)

COMMISSIONER JONAS: But there are established methods in which that occurs right now and we have data on that actually.

COMMISSIONER GORDON: We are going to have to end this. Thank you very much, all of you.

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OPEN SESSIONS (Continued)

MS. CHANG: That would be Howard Fidler, John Toft, Marilynn Anderson, Chu Wu, Jeff Dusek and Richard Pavek.

COMMISSIONER GORDON: One of the things we are trying to do and I hope I am not abrupt -- too abrupt, firm I suppose, is because we really -- we are already running about 20 minutes behind time and we would like to end pretty much on time and give everybody the same amount of time and make it possible for people who have to go but who want to be here for the whole time to leave not too late.

Okay. First will be Howard Fidler.

HOWARD FIDLER, DC

AMERICAN CHIROPRACTIC ASSOCIATION

DR. FIDLER: Good afternoon. My name is Dr. Howard Fidler. I am a practicing doctor of chiropractic in St. Louis Park, Minnesota. I am here today as the Minnesota delegate from the American Chiropractic Association. Since my time is limited, I would like to provide the Commission with the following policy recommendations as they relate to access, reimbursement and education.

Federal statutory requirements that impede the use of proven CAM services in federal health care programs must be relaxed. Currently many federal programs do not reimburse for complementary and alternative treatments. These statutory limitations are impeding research by not allowing CAM practitioners to participate in federally sponsored coordinated-care research efforts. In addition, doctors of chiropractic and other CAM practitioners are further impeded by statute from providing their services to the general public through the National Health Services Corps. By not being recognized as providers under these programs, doctors of chiropractic as well as other CAM providers are not provided the opportunity to prove the cost effectiveness and efficacy that their services provide. Statutes must be changed to allow for all proven CAM providers to participate in all federal programs.

Patients should be afforded the ability to seek treatments by proven complementary and alternative providers without the referral of a medical gatekeeper. Currently, MDs are not trained and educated to appropriate refer

patients to CAM providers. Also, there is an issue of competition and a history of bias. In addition, both private and federal insurance programs should not limit a practitioner's practice. Proven and/or licensed CAM practitioners must be recognized and reimbursed for all reasonable and necessary services provided to their patients.

Recommendations should be made to ensure that CAM providers not be reimbursed at a lower rate or be discriminated against in any fashion based on their training and licensure. A consumer's freedom of choice to select among all state-licensed health care providers is an essential attribute of any effective and responsible national health goal. A mandate of nondiscrimination ensures that one class of provider will not be given a competitive edge over other providers for the service.

While the ACA applauds the commissions interest in educating medical school students on the merits of CAM therapies, care should be taken that these courses are not misinterpreted as teaching a specific CAM procedure. These courses should merely provide the medical school

student with exposure to the principles and practices in order to refer when necessary.

The commission must provide specific recommendations to address the current problem with reimbursement disparities that is occurring at an alarming rate with private insurance. The commission must recommend that federal agencies work with the complementary and alternative therapy communities in the development of policy by contracting or hiring CAM provider as part of their health care policy teams. Unless federal agencies begin to look outside the medical model and begin to embrace wellness and prevention, federal laws will continue to be ineffective in providing consumer access to proven CAM practices.

Thank you for the opportunity to present the views of the American Chiropractic Association. I would be happy to answer any questions.

COMMISSIONER GORDON: Thank you.

John Toft?

JOHN TOFT, DC

FUNCTIONAL MEDICINE CHIROPRACTIC CENTER

DR. TOFT: Hello. I am John Toft, a

chiropractor.

I am practicing a model of health care that combines my primary care chiropractic training with the most current, cutting edge, medically based and referenced research of functional medicine, delivered through a very specialized arena of chiropractic, applied kinesiology.

This is essentially the model that is being used at Alternative Medicine, Incorporated, in Chicago, that is performing in a pilot project with Blue Cross/Blue Shield of Illinois.

In speaking with Dr. Steven Groft, I believe you folks are aware of this pilot project, but may not have seen the most recent numbers. They are now showing after two years of treatment a 66 percent overall health care cost savings. Dr. Richard Sarnat will be coming to you in Washington next month to speak about this program and I hope you will give him very special attention.

One major item to me that has not been previously discussed is what makes this group of specially credentialed physicians so effective

and that is the very specialized technique of applied kinesiology, which the majority of the DCs in the group are using.

Applied kinesiology or AK for short is a system of analysis that aids in the diagnostic process. This technique has been evolving over the past 35 years and gives a practitioner the ability to much more effectively find and fix the underlying causes of musculoskeletal problems and also allows us to very specifically find nutritional deficiencies, food allergies, toxic conditions, and also emotional issues that thereby give us the ability to improve organ system functions; where organs have lost their organ reserve energy and are on the downhill slide towards an eventual disease state, usually decades in the future.

The Human Genome Study has shown that disease exists on the genes. What Dr. Jeff Bland's work has already shown years ago is that the combined effects of environment and lifestyles is affecting communication molecules that turn the diseases on or off at the level of the chromosomes. The expression or phenotype of the genes is controllable.

I have included a work product of mine on ten floppy cassettes, nearly 500 cutting edge, medically referenced articles in 44 categories of disease that educate one on how the whole body works together in health and disease.

I feel that this is the most exciting time there could ever be in health care. We are showing an absolute revolution and a paradigm shift in the health care delivery process; from a disease care model to a truly preventative model that can find and fix organ system weaknesses before disease has had a chance to develop.

I have included several additional writings of mine and will be more than willing to assist you in any way I can.

Thank you.

COMMISSIONER GORDON: Thank you.

Marilynn Anderson?

MARILYNN ANDERSON

THE FELDENKRAIS GUILD OF NORTH AMERICA

MS. ANDERSON: Dr. Moshe Feldenkrais defined health as "the capacity of a person to live out his or her avowed and unavowed dreams."

I want to live in a dynamic world populated by these healthy people. As a Feldenkrais practitioner, my role is not to work with specific maladies and conditions but to teach and encourage comfortable, efficient and effective functioning of people in their environments.

Feldenkrais practitioners meet people in whatever state of functioning and health that they are and assist them to move gently and easily towards where they want to be. Those desires may be as basic as breathing more fully in a wheelchair or as complex as surviving a day comfortably while sitting attentively perhaps at a meeting.

Through a series of guided, often developmental, movement sequences, either privately or in a group setting, the Feldenkrais practitioner encourages fluid systemic movement patterns. The client learns how to notice how they interfere with and detour from their intention, while learning how to safely experiment and discover alternative routes and strategies that are both more comfortable and fruitful. This same process holds true for the

person recovering from a stroke and a high performance athlete.

The Feldenkrais method and other somatic education modalities are an essential component of the health and health education systems. However, we are not part of the medical system as it is conventionally defined. Now it often happens that through the Feldenkrais process, as the client becomes more self-integrated and organized, that a shoulder may unfreeze, a knee stops swelling, a jaw softens, an ankle quits chronically spraining, blood pressures lowers, or a back aligns better.

These sympatomica events create interesting borderlines between the medical system and the somatic education systems and warrant exploration and research. but to a Feldenkrais practitioner, these would be merely incidental asides to the successful functional acts of a person spontaneously playing with a grandchild on the floor, delighting in a walk around a lake, simply rolling over in bed, sleeping well, shoveling snow without a three-day recovery, or comfortably persisting at a computer until the book is complete.

People productively follow their dreams with pleasure when functioning fully and confidently in their lives. They are healthy.

Whatever policies arise from this commission, the Feldenkrais Guild requests that you approach each modality respectfully and in consultation with its professional organizations. Please be cautious about placing nonmedical practices into a medical framework.

The most healthful practice around may be a walk on the beach but certainly no one wants to need a prescription to do it along with a qualified walker.

We have an enormous amount to contribute towards the healthy functioning and injury prevention of the citizenry. We welcome the shift in the medical system towards the health and health education systems, and look forward to a continued blossoming relationship within that context.

COMMISSIONER GORDON: Thank you.

Chu Yongyuan Wu.

CHU YONGYUAN WU, MA

HMONG SHAMAN RESEARCH PROJECT

MR. WU: Thank you.

I am one of the young considered healer being chosen so I appreciate to be here today to talk about Hmong Shamanism in America.

Shamanism is one of the oldest spiritual healing that is still practiced by some indigenous people around the world. Shamanism is very much alive with the Hmong people here in Minnesota. The new immigrants in the United States. To the Hmong people, Shamanism is an ancient method of healing but to the Western mind it is a new alternate method of treatment.

According to the Hmong Shaman belief, all living species have a body, soul and spirit. When a person becomes ill, the shaman believes the problems are either caused by organic disease, lost soul or because the spirit of the person departs from the body. The human body is somehow out of balance; therefore, it needs the medicine healer to conduct healing ceremonies in which to determine the cause of the problems.

A shaman is someone who is chosen by the Creator and possesses the power to heal throughout his or her lifetime. No one decides to be a shaman. When the spirit enters into the person, other shamans come to assist him or her

in starting the process for one or two days. He or she begins to practice the ceremonies within the family and then eventually is invited to help others in the community.

The shaman's role is to cure the soul and the spirit, to drive the demons out of the body and out of the family, and then to help in bringing back the spirit and soul to the body in order for the person to become well again.

Almost all the shamans I have known during the last 20 years and those whom I interviewed in the "Shamanism in Minnesota and Patient Choices" research project are working to cure the soul and spirit, not the disease. He or she is not a medical doctor that attended school, learned about the subject or obtained a degree. Their knowledge and skills are gifts from God. Their services are voluntary and free.

I recommend that health care in this country should be more open to alternative medical treatments and recognize the important values and healing systems of all cultural practices. We need more study about the different types of treatments in order to

develop more available resources for human needs before some of those valuable healings are lost forever.

Health care providers and churches in this country should not abandon the different types of religious treatments, herbal medicines and cultural practices, but they should work together to save lives. Shamanism is alive and still has much to offer to the modern world. We need to find ways to balance the system and to invite other healers to be part of the medical treatment team.

Thank you.

COMMISSIONER GORDON: Thank you very much.

(Applause.)

COMMISSIONER GORDON: Jeffrey Dusek?

JEFFERY DUSEK, PhD

MIND/BOND MEDICAL INSTITUTE

DR. DUSEK: Dr. Gordon and distinguished commissioners, thank you for allowing me to speak to you on behalf of the Mind/Body Medical Institute, which was founded in 1989 by Dr. Herbert Benson.

The Mind/Body Medical Instituted is

located in the Beth-Israel Deaconess Medical Center, one of Harvard Medical School's teaching hospitals.

Over the past decade, researchers at the Mind/Bond Medical Institute have been conducting evidenced-based research examining the medical interaction between mind and body, including a current HCFA demonstration project.

Over the past decade, two national surveys indicate that Americans are increasingly relying on the use of alternative medicine treatments alone or as a supplement to traditional medical treatments.

Given that many Americans are already using alternative treatments that have not been adequately tested, researchers must continue to explore the safety and proposed efficacy of these treatments.

To do adequately achieve this aim, my recommendations are as such:

(1) CAM therapies must be required to adhere to the same scientific rigor expected of traditional medicine. Contrary to the belief of some CAM practitioners, current clinical research tools can be used to objectively and

fairly examine the efficacy of CAM treatments.

(2) In this process, it is imperative to examine whether the CAM treatments themselves are effective in treating illness, or whether the belief in the CAM treatments plays a fundamental role in treating illness.

(3) Until clear scientific evidence of safety and efficacy of CAM treatments is obtained, safeguards should be implemented to protect Americans from potential harm.

I am concerned that not all users of CAM are as well informed of the risk of CAM as are my esteemed co-presenters. Simply accepting the treatment as a safe -- simply accepting that a treatment is safe based on anecdotal and not clinical evidence is not only unacceptable, it is dangerous.

(4) Specifically it will be important to determine the safe and effective doses of treatments, an acceptable duration of treatment, and identifying which patient population may be best suited for a given treatment.

(5) Mind/body medicine is an excellent example of how nontraditional research can adhere to the scientific method employed in

traditional medicine. Positive results from mind/body medicine research are based on scientifically collected evidence, not anecdote.

(6) Although the National Center for Complementary and Alternative Medicine's budget has dramatically increased over the last several years, additional and adequately funded research initiatives are desperately needed to carry out this important work.

I have added on based on what I have listened to today.

It may be worth reminding ourselves that the goal of the clinical trial is to examine the efficacy of treatment for use in future patients.

The goal of clinical treatments provided by practitioners is for current treatments or for current patients. Coming to grips with those -- reconciling those differences between future patients and present patients, I think, is part of the difficulty we are having with research applied in this modality.

Thank you.

COMMISSIONER GORDON: Thank you.

Richard Pavek?

RICHARD PAVEK

THE SHEN THERAPY INSTITUTE

MR. PAVEK: Thank you.

There are two major groupings of complementary and alternative health practices; each has different goals. The more established, such as acupuncture, chiropractic and homeopathy are attempting to convince medical science that they are effective so that they may be accepted into mainstream medicine. This will require a great many expensive double-blind controlled clinical trials. This need is slowly being met at the insistence of Congress and the American people, by the National Center for Complementary and Alternative Medicine in association with other centers.

However, a number of health care options by their very nature can never be brought into mainstream medical practice. Some require more time than licensed practitioners could provide, some are highly individualized to the client and others defy accepted medical explanation, relying on empirical evidence of effectiveness for proof. NCAM has limited funding and few of these options are even on NCAM's list of

possible candidates for investigation. Most will never be studied.

For years, mainstream medical science has, without proof, dismissed these methods as being merely the results of imagination or placebo. The public, being unversed in medical dogma, uses what works; whether it works by a valid physical effect presently unrecognized by medical science or by imagination, placebo, the practitioner's personality or hair coloring is of little matter. The fact that it works is enough.

Many of these systems, such as my own, SHEN therapy, work to promote emotional health, noticing that when emotional health improves, physical health improves. A principle vaguely understood in medicine but which conventional medicine has no means to effect. Maintenance of emotional health is not a part of the standard medical curriculum. These CAM therapies fill that gap.

All CAM therapies lie in a vaguely defined area surrounding mainstream medicine's excessively broad and monopolistic territory. When CAM options have been effective enough to

be noticed by the medico/legal authorities, they are often fined and put out of business, not for causing harm or endangerment but because they were in competition with, and sometimes more effective than standard medical practice.

Minnesota's Health Freedom Act protects the rights of its citizens to receive the health care options each of them determines suits them best. The act appropriately defines what the unlicensed health care practitioner may safely do and not do, and legally enforces ethical responsibility and full disclosure, actions not presently required of the medical profession.

Freedom of health care choice should be the personal right of every American citizen but without protecting the practitioner's freedom to deliver CAM practices to those who desire them, the public's freedom to exercise their health care options will be lost.

I have returned here to my home state from my current home in Sausilito, California, to urge this commission to strongly endorse national legislation similar to the Minnesota Act. It is vital to the future of these health care options and clearly is in the best interest

of the American people.

Thank you.

(Applause.)

DISCUSSION

COMMISSIONER GORDON: Thank you, Richard.

Questions? Linnea?

COMMISSIONER LARSON: No.

COMMISSIONER GORDON: No.

Joe?

COMMISSIONER PIZZORNO: I do have one question.

The applied kinesiology is an interesting procedure and I have heard assertions that there is research documenting its efficacy. Could you review what the research is in AK and how it has been tied to conventional diagnostic procedures?

DR. _____: There is not nearly enough research specifically to applied kinesiology --

COMMISSIONER GORDON: Come close to the mic, please?

DR. _____: There is not nearly enough research in applied kinesiology directly