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WHCCAM Commissioner Notebook, Day 2, Washington DC, March 26-27, 2001 [1]

2011-0568-S

kc806

RESTRICTION CODES

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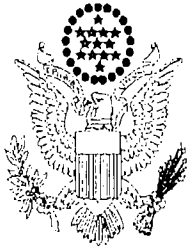
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II. Day 1: INFORMATION

Divider Title: _____



White House Commission on Complementary
and Alternative Medicine Policy

Meetings on
CAM Information Development and Dissemination
CAM in Self-Care and Wellness

March 26-27, 2001

Hyatt Regency Hotel on Capitol Hill, Washington, DC

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III. DAY 2:
SELF-CARE and WELLNESS

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Divider Title: Astin

CAREER BIOGRAPHY

Full Name: John A. Astin

Present Post: Assistant Professor, Department of Family Medicine, Complementary Medicine Program, University of Maryland School of Medicine

Dr. Astin received his Ph.D. in Health Psychology from the University of California, Irvine. From 1997-1999, he was a research fellow in the Complementary and Alternative Medicine Program at the Stanford University School of Medicine. In February of 2000, he joined the Complementary Medicine Program at the University of Maryland School of Medicine as a faculty member and director of mind-body research. His research and clinical work have focused on several related areas: 1) the use of mind-body therapies, particularly mindfulness meditation, to treat various health-related problems; 2) psychosocial factors associated with use of complementary/alternative medical therapies; 3) the psychological construct of control and its relationship to mental and physical health; and, 4) the role of spirituality in healthcare. His research has appeared in such journals as *Archives of Internal Medicine*, *JAMA*, and the *Annals of Internal Medicine*. He is the co-author (with Deane Shapiro) of the book: "Control therapy: An integrated approach to psychotherapy, health, and healing." Along with his scholarly pursuits, Dr. Astin is also an accomplished singer, songwriter and recording artist having produced 5 albums of original music that are distributed worldwide.

Presentation by John A. Astin, PhD to the White House Commission on
Complementary and Alternative Medicine

March 27th, 2001

I've been asked to provide you with an overview for today's proceedings, a larger context if you will to begin our dialogue and discussion examining the links between CAM, wellness, self-care, and prevention. Let me first begin with a couple of definitions of terms.

Wellness orientation – 1) the recognition that health involves more than merely the absence of disease (i.e., human beings are capable of realizing or manifesting higher, more optimal levels of energy, creativity, and psychophysical well-being), and, 2) the belief that health more broadly conceived encompasses not merely physical well-being but mental-emotional, social, environmental, relational, and spiritual/existential well being as well.

Self-care –the myriad ways in which individuals, families, and communities address health-related issues without the use of (or in combination with) the services of health care professionals. [“Self-care” *can*, of course, also involve the decision to utilize professional services.]

The concepts of wellness, self-care and prevention are also frequently embedded within one another. For example, the University of California Berkeley Wellness Letter includes in its definition of wellness the following:

“a preventive way of living that reduces – sometimes even eliminates – the need for remedies. Wellness emphasizes personal responsibility for making the lifestyle choices and self-care decisions that will improve the quality of your life. One crucial tenet is that preventing illness is even more important than treating it, especially since many chronic diseases are incurable.”

Let me now turn to the question: to what extent are these two trends in medicine – wellness and self-care -- related to CAM? Clearly, there are strong thrusts of both the wellness and self-care orientations as defined above embedded within much of CAM. In fact it is these very dimensions of many CAM therapies (i.e., their emphasis on achieving more optimal states of well-being, their tendency to address the whole-person, and their focus on empowering patients to care for their own health and well being) that appear to motivate many patients and consumers to utilize these approaches. Let us now look at little more carefully at these three dimensions – optimal well-being, a holistic orientation, and patient self-care and empowerment – and their relationship to CAM.

1. Optimal well being – There is certainly an emphasis within many CAM therapeutic modalities upon not simply overcoming or preventing illness/disease but on realizing more optimal levels of functioning. Many CAM therapies hold either explicit or implicit beliefs that humans are capable of very high (even extraordinary) levels of physiological, mental, emotional, and spiritual well being. In fact, many approaches in CAM posit that our so-called "ordinary" and relatively disease-free state of physical and mental functioning is in many respects sub-optimal (i.e., we are often not realizing our full potential as humans). This orientation is particularly evident in many of the mind-body therapies such as meditation, yoga, Tai Chi, and Qi Gong. In fact, most of these practices were developed not so much to treat disease but to facilitate the development of various "positive" states of health such as equanimity, harmony with oneself and the world, compassion, mental clarity-concentration, heightened perceptual

sensitivity (e.g., to subtle energies), and spiritual insight or realization. It is interesting to note that even in their more secularized versions (e.g., Benson's "relaxation response"), for many individuals, these practices appear to give rise not merely to improved physical health and functioning (e.g., lowered blood pressure, heightened immune function) but to life transforming spiritual/religious experiences and insights.

Fuller in his marvelous book "Alternative Medicine and American Religious Life" points out that historically, the interest in various unconventional forms of health care in the early 20th century -- from vegetarianism to osteopathy and chiropractic as well as various forms of "mind cure" -- was very much intertwined with interest in less conventional, more esoteric forms of spirituality and religion ("New Thought" religious movements such as Science of Mind and Christian Science, Eastern mystical/contemplative traditions). One can see for example in the writings of the founders of chiropractic, clear evidence of this link in such metaphysical concepts as the existence of a Universal, Divine Energy or Intelligence ("Innate") whose awakening and free flowing through the spine and nervous system was believed to hold the key to good physical as well as mental and spiritual health and well being. Although less well studied, there is also the notion that many of the nutritional supplements, nutraceuticals, and herbal products in current use are capable of optimizing physical and mental functioning along with preventing and treating disease (e.g., healthy people using Ginkgo Biloba to improve memory).

2. Whole person care-- It could be argued that most CAM therapies embrace the wellness perspective in that they view health more holistically. For example not only in mind body medicine but in such approaches as acupuncture, homeopathy, Ayurvedic Medicine, TCM, and various forms of bodywork, there is a fundamental recognition that non-physical factors play a vital role in the maintenance of good physical health. As a rule, one also sees in many CAM therapies an appreciation of and tendency for practitioners to place greater emphasis upon the crucial role that lifestyle/behavioral factors play in shaping health.
3. Self-care (or empowering patients to care for themselves) -- Jon Kabat-Zinn, the originator of mindfulness based stress reduction (MBSR), one of the more prominent mind-body therapies currently being integrated into health care settings in this country has suggested that the medicine of the future (as exemplified by interventions such as MBSR) will be *participatory* medicine, a medicine in which patients are actively engaged in the process of becoming well and of discovering their own inner and outer resources for maintaining health and wholeness. Along these lines, one does see in many CAM therapies a focus on patients becoming proactive participants in their own healthcare. In fact, a huge portion of CAM use *is* self-care (particularly evident in the area of nutritional supplements and herbs which by and large are used without any input from health professionals).

As can be seen in this brief discussion, both wellness and self-care are indeed key components of many (though certainly not all) CAM therapies, as I will discuss in a

moment. However, we must also ask the question: to what extent is CAM being included as part of the conventional wellness and/or self-care movements? For the most part, the answer is not very extensively (although I believe this may be changing). For example, the well known book "Take Care of Yourself," by Vickery and Fries, now in its 37th printing, the authors make almost no mention of any CAM approaches to wellness and self-care (with the exception of a few very minor references to relaxation and stress reduction). Further, it is interesting to note that at the outset of the book, they state that there are "only seven major ingredients in a plan for good health": exercise, diet, not smoking, alcohol moderation, weight control, avoiding injury, and professional prevention practices (e.g., immunization, screening for breast cancer). One can see a marked difference between this orientation to wellness and that typically seen in CAM in that no mention is made of how we interface psychologically, emotionally, and/or spiritually with ourselves and the world in terms of this being a potentially important ingredient of "health."

In closing, as it relates to today's topic of discussion, I'd like to suggest some potential areas the commission may want to focus on as it considers its recommendations to the President and Congress.

First, I think it is of vital importance that the medical research community begin to examine the efficacy of CAM in terms of the prevention of disease. Our research efforts to date in the CAM field have been focused almost entirely upon the treatment rather than prevention of health related conditions. This trend of course parallels the general trend

within conventional medicine that underemphasizes prevention both in terms of how we allocate research dollars and as far as what we are willing to reimburse. For example, despite massive amounts of research showing both the significant clinical and cost benefits of worksite health promotion programs, insurers remain reluctant to invest in such services, in part because the gains may not be immediately apparent but can often only be realized over the long term. I think that some of the mind-body therapies may hold particular promise in terms of prevention since they are aimed directly at transforming psychological, attitudinal, and attentional patterns (such as excessive stress reactivity) that have been shown to negatively impact health. Given the well-documented effects of various “mind” factors such as depression, anxiety, loss of sense of control, and anger/hostility upon disease states, positively transforming these (e.g., through such mind body practices as meditation, yoga, or relaxation) could have profound public health implications. It may also prove fruitful to examine the potential for other CAM modalities (such as acupuncture, various forms of bodywork, etc) to be used as preventive healthcare (i.e., not simply to treat symptoms or disease). Along these lines, I think it is vital that those in the CAM research and clinical communities begin to dialogue with those in the more conventional preventive medicine arenas.

Second, I think it will be important to begin studying the effects of various CAM therapies in healthy populations, not solely in terms of preventing disease and illness but in terms of promoting more optimal states of health and well being as I discussed earlier. For example, if you take a relatively healthy, disease-free individual and give that person weekly acupuncture or bodywork sessions, do they begin to manifest greater levels of

energy, vitality, and mental-emotional balance? While I was at Stanford, we began a study that is now fully underway to examine the effects of a multi-modal lifestyle intervention program developed by Mike Murphy and George Leonard, Integral Transformative Practice (ITP). This primarily peer led (i.e., largely self-care) program involves group emotional support, the practice of meditation and various self-awareness skills drawn from the martial arts, as well as gentle exercise. We are now studying the effects of the ITP program in healthy older adults to see if it improves cognitive function, physiological balance, and overall quality of life including spiritual health and well being.

Lastly, I want to say that I believe it is vital that the CAM community begin to break down rather than create barriers between themselves and the conventional medical community. For example, I really believe it is a mistake to pit CAM, whether ideologically or practically, against conventional medicine for several reasons. One, CAM as we know but must constantly remind ourselves is not a homogeneous phenomenon. While there are certainly theoretical and practical aspects that tie many of the disparate CAM therapies together, there is also enormous variability within CAM, maybe as much as there is between CAM and conventional approaches. To say for example that "CAM is holistic while conventional medicine is not" (a position implied by many CAM proponents) is simply an oversimplification and quite frankly wrong. CAM can be and is used by the public and practitioners in ways that are not terribly holistic. For example, one can take or prescribe St John's Wort in exactly the same way that one might take or prescribe Prozac without looking at the whole person, their relationship to their work, their sense of purpose and meaning, their sense of social isolation, and so on,

all of which may be playing a significant role along with biochemical factors in precipitating depression. To reiterate, the use of CAM does not necessarily reflect a holistic/wellness approach on the part of patients or providers.

It is also important to remember that CAM does not have a corner on the wellness-holistic health “market” as there are certainly strong currents moving within mainstream medicine now that are stressing the importance of treating the whole patient, that recognize health is more than the absence of disease, and that realize the *relationship* between doctors and patients is of vital therapeutic importance. For these reasons, it is crucial that researchers and practitioners within the CAM community seek to partner, dialogue and collaborate with those within conventional medicine who share in these fundamental philosophical orientations.

In closing, I’d like to say that while the identification of new therapeutic tools is of obvious importance, I’ve long felt that in the end perhaps the greatest contribution CAM may make is in reminding the whole of medicine of the crucial importance of caring for the whole person, the need for care to be both relationship-centered as well as patient-centered, and the vital importance of emphasizing wellness, prevention and patient self-care.

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University of Cambridge, England	M.A.	1980	Medical Sciences
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Duke University Medical Center	Residency	1984-1987	Pediatrics
University of North Carolina, Chapel Hill	Fellowship	1987- 1990	Developmental Peds

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1983-1984: Intern in Medicine and Surgery, Cambridge Area Health Authority, England
1984-1987: Pediatric Resident, Duke University Medical Center, Durham
1987- 1990: Fellow, Developmental Pediatrics, Center for Development and Learning, University of North Carolina, Chapel Hill
1991- 1994: Director, Pediatric Rehabilitation Clinic, UNC Hospitals
1994 - present: Medical Director, Olson Huff Center for Child Development

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1990- 1994: Assistant Professor of Pediatrics, UNC Dept of Pediatrics
1995 - present: Clinical Associate Professor, UNC Dept of Pediatrics
1996- present: Committee on Children With Disabilities, American Academy of Pediatrics
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Sandler A.D., Sutton KA, DeWeese J, Girardi MA, Sheppard V, Bodfish JW: A double-blind placebo-controlled study of synthetic human secretin in the treatment of autism and pervasive developmental disorder. New England Journal of Medicine 341, 1801-6, 1999.

Sandler, A.D., Huff, O. The pediatric assessment of the schoolage child. In Levine MD, Carey WB, Crocker AC (Eds.) Developmental-Behavioral Pediatrics (Third Edition), WB Saunders, Philadelphia, pp 696-705, 1999.

Sandler, A.D. Living With Spina Bifida: A Guide for Families and Professionals. UNC Press, 1997.

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- Counseling families who choose complementary and alternative medicine for their child with chronic illness or disability. Pediatrics 2001 (in press).
- The treatment of neurologically impaired children using patterning. Pediatrics 104, 1149-1151, 1999.
- Care coordination: Integrating health and related systems of care for children with special health care needs. Pediatrics, 104, 978-981, 1999.
- Learning Disabilities, Dyslexia, and Vision: A subject review. Pediatrics, 102, 1217-1219, 1998.
- Auditory integration training and facilitated communication for autism. Pediatrics, 102, 431-433, 1998.

AMERICAN ACADEMY OF PEDIATRICS

Committee on Children With Disabilities

Counseling Families Who Choose Complementary and Alternative Medicine for Their Child With Chronic Illness or Disability

ABSTRACT. The use of complementary and alternative medicine (CAM) to treat chronic illness or disability is increasing in the United States. This is especially evident among children with autism and related disorders. It may be challenging to the practicing pediatrician to distinguish among accepted biomedical treatments, unproven therapies, and alternative therapies. Moreover, there are no published guidelines regarding the use of CAM in the care of children with chronic illness or disability. To best serve the interests of children, it is important to maintain a scientific perspective, to provide balanced advice about therapeutic options, to guard against bias, and to establish and maintain a trusting relationship with families. This statement provides information and guidance for pediatricians when counseling families about CAM.

ABBREVIATION. CAM, complementary and alternative medicine.

STATEMENT OF THE PROBLEM

The use of complementary and alternative medicine (CAM) is increasing in Western countries. Indeed, more than one third of the adults in the United States have used CAM in recent years.^{1,2} Pediatric use of CAM is especially likely among children with chronic illness or disability. Up to 50% of children with autism in the United States probably are using some form of CAM.³ In many instances, the physician providing medical care is unaware of the concurrent use of CAM. Increasingly, pediatricians providing care for children with chronic illness or disability are discussing CAM with families or are asked to prescribe such treatments. Pediatricians' expertise in biomedicine may not adequately prepare them for discussion of CAM.

BACKGROUND INFORMATION AND DEFINITIONAL ISSUES

CAM has been defined as "a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historic period."⁴ An enormous array of unconventional therapies may be used as alternative therapies (instead of conven-

tional treatments) or as complementary therapies (in addition to conventional treatments) (see Fig 1).

Currently, courses on CAM approaches are offered in the majority of US medical schools.⁵ The US government established the Office of Alternative Medicine (now the National Center for Complementary and Alternative Medicine) in the National Institutes of Health to carry out scientific study of CAM.⁶

Biomedicine is based on laws of science and the rigorous applications of the scientific method. It may aptly be called scientific medicine or evidence-based medicine. Disease is explained by pathophysiologic processes, and treatments are designed to affect these processes. The term *biopsychosocial medicine* has long been used to describe a biomedical model that recognizes the importance of psychosocial factors.⁷ Biomedical treatments are based on accumulated evidence of effectiveness from peer-reviewed scientific research. There is a hierarchy of research evidence, at the top of which is the controlled clinical trial. Many accepted biomedical treatments lack evidence of effectiveness from controlled clinical trials (eg, the use of physical therapy in the care of the premature infant). Unproven therapies also may be based on pathophysiology and limited research, but they lack accepted standards of proven effectiveness (eg, the use of immunoglobulins in the treatment of autism).⁸ Alternative therapies are based on a variety of non-biomedical beliefs and usually have not been subjected to clinical research. Most are supported by anecdotal evidence, but some alternative therapies have proven effectiveness. For example, preliminary studies of acupuncture in addiction treatment show positive results.⁹ In time, such proven therapies may come into wider use and lose their "alternative" status.

Biopsychosocial medicine and CAM have at least one thing in common: both recognize that the relationship between physician-healer and patient is integral to the success of treatments offered. This is part of the age-old "art" of medicine and is a basis of the placebo response.¹⁰ The emphasis of biomedicine on pathophysiology and on technical outcomes has reinforced the perception among some families that physicians undervalue their relationships with their patients. The failure of biomedicine to recognize and respond adequately to individual differences among patients is one reason families turn elsewhere and has contributed to the increasing use of CAM.

The distinctions among unproven therapies, CAM, and biomedicine may become especially blurred in the care of children with chronic illness or disability.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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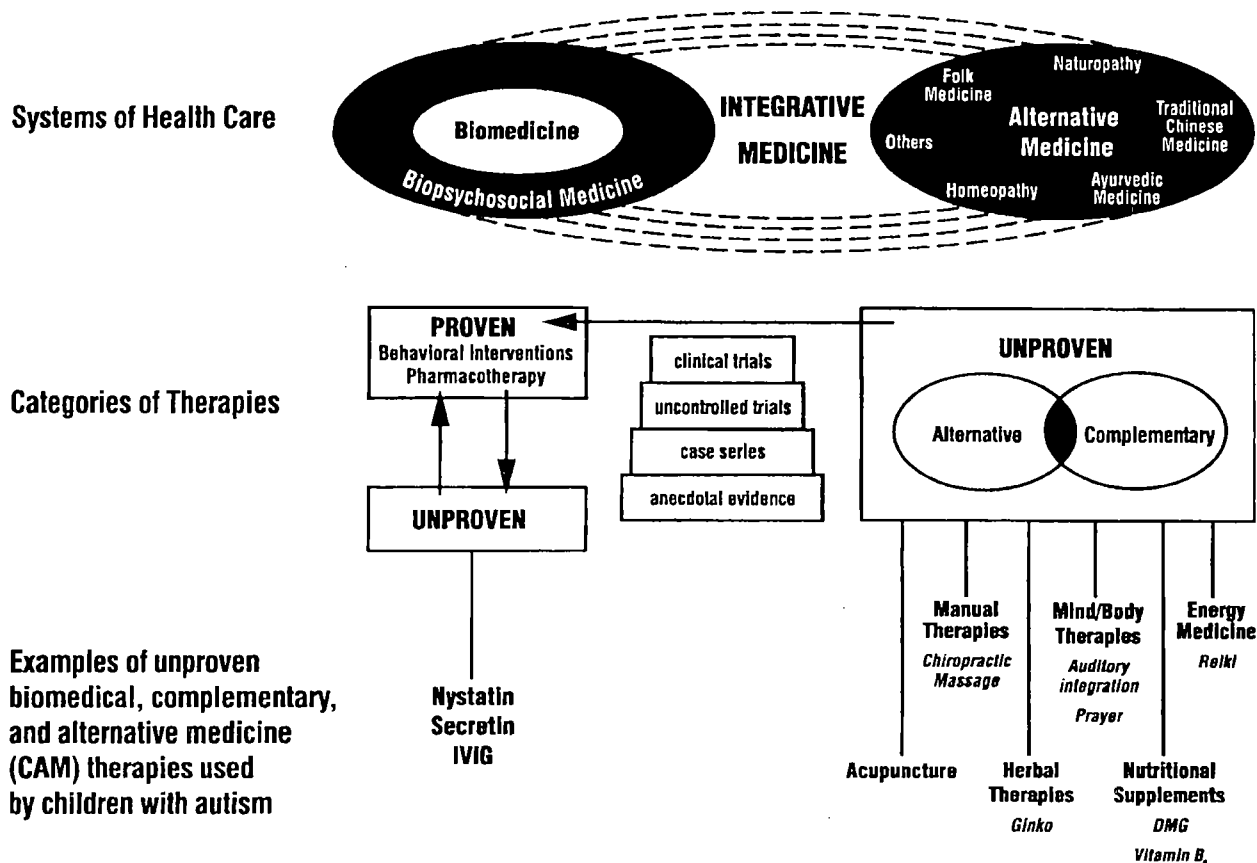


Fig 1. Biopsychosocial medicine and alternative medicine are broad systems of health care that encompass theories, practices, and therapies. Integrative medicine is a term loosely used to describe these systems used in combination. Therapies (whether biomedical, complementary, or alternative) are considered proven or unproven based on a hierarchy of evidence.

Some conventional biomedical therapies lack proof of effectiveness, and some unproven and alternative therapies may in time prove effective. Also, some alternative therapies conceivably may have placebo effects, which confer additional therapeutic gain and enhanced quality of life. These factors may present significant challenges to the health care professional. Moreover, there are no published clinical guidelines regarding the use of CAM in the care of children with chronic illness or disability.¹¹

WHY PARENTS OF CHILDREN WITH CHRONIC ILLNESS OR DISABILITY CHOOSE CAM

Parental questioning of a child's diagnosis, treatment, and prognosis reflects a normal process of adjustment to the permanence or chronicity of the condition and the desire to ensure the best possible outcome for their child. Many parents become frustrated with biomedical therapies because of complexity, discomfort, bewildering technology, or uncertainty of cure. Indeed, for some conditions, biomedicine has little or nothing to offer. Also, families may be frustrated because they have not been sufficiently involved in the development of a care plan. The media, condition-specific publications, and parent-to-parent contacts provide essential opportunities for families to learn about resources, including CAM. Furthermore, the Internet has dramatically increased exposure of families to sophisticated market-

ing, testimonials, and unproven claims. Some parents are attracted to simple explanations of causality, some by an approach perceived to be more "natural." Many try a succession of alternative therapies, believing that any approach that does no harm is worth a trial. For almost all, CAM approaches represent an attempt to gain a sense of control over their child's chronic illness or disability and to improve quality of life.

BALANCING FAMILY-CENTERED CARE WITH THE ETHICAL RESPONSIBILITY OF THE PEDIATRICIAN

The "medical home" concept emphasizes that care should be compassionate and family-centered. Mutual participation in decision making and informed consent are essential elements of respectful care.¹² Decisions and plans should be made through a process of collaborative decision making in which the family receives complete and unbiased information needed to understand and make informed decisions. The quality of the relationship between the health care professional and patient with chronic illness has been shown clearly to affect outcomes.¹³ Honest and supportive relationships with health care professionals can help parents cope¹⁴ and promote the child's independence.¹⁵ Such relationships are strengthened when health care professionals understand the perspectives of the family, provide care with flexibility, and attempt to meet the family's needs and expecta-

tions. Clearly, it is optimal for children with chronic illness or disability to receive health care in a setting that is family-centered. At the same time, pediatricians have an ethical responsibility to guard the welfare of children by ensuring that any treatment they endorse is "in accordance with science and proven experience."^{16,17} Dilemmas may arise when families ask their pediatrician to endorse or to provide a therapy that is considered by the pediatrician not to be in the best interests of the child. There may be evidence of the possibility of direct harm, unknown risks, or concerns about indirect harm to the child. The pediatrician is in a position to balance a commitment to family-centered care with the ethical responsibility to guard the welfare of children.^{18,19}

SUMMARY/CONCLUSION

The use of CAM approaches in the United States is increasing, especially among children with chronic illness or disability. Distinctions among unproven therapies, CAM, and biomedicine may become blurred, presenting special challenges to the pediatrician. To best serve the interests of children, it is important to provide balanced advice about therapeutic options, to guard against bias, and to establish and maintain a trusting relationship with families. Although the focus of this statement is chronic illness or disability, the recommendations that follow also may apply to the use of alternative medicine in other pediatric domains.

RECOMMENDATIONS FOR PEDIATRICIANS WHO DISCUSS ALTERNATIVE, COMPLEMENTARY, AND UNPROVEN THERAPIES WITH FAMILIES

1. Seek information for yourself and be prepared to share it with families.

Families are likely to be appreciative of information you have obtained through literature searches. Reviews of CAM discuss currently popular alternative approaches and their attendant risks.^{3,20-22} Also, Appendix I shows several Web sites that may be useful resources.

2. Evaluate the scientific merits of specific therapeutic approaches.

Critical evaluation of claims of effectiveness requires training in the scientific method and an understanding of processes of disease. This training is equally important for evaluating conventional biomedical treatments and alternative therapies. Many CAM approaches are based on inconsistent or implausible biomedical explanations, and claims of effectiveness rest on anecdotal information and testimonials. The pediatrician can be uniquely helpful to parents seeking an assessment of the merits of specific therapies by evaluating such therapies and providing guidance.

3. Identify risks or potential harmful effects.

Alternative therapies may be directly harmful by causing direct toxic effects, compromising adequate nutrition, interrupting beneficial medications or therapies, or postponing biomedical therapies of proven effectiveness. Indirect harm may be caused by the financial burden of the alterna-

tive therapy, other unanticipated costs (eg, the time investment required to administer the therapy), and feelings of guilt associated with inability to adhere to rigorous treatment demands. If a child receiving alternative therapy is at direct or indirect risk of harm, the pediatrician should advise against the therapy. In some circumstances, it may be necessary for the pediatrician to seek an ethics consultation or to refer to child welfare agencies. If there is no risk of direct or indirect harm, a pediatrician should be neutral.

4. Provide families with information on a range of treatment options (avoid therapeutic nihilism).

Although effective treatments to cure the underlying condition or restore function may be lacking, there may be adjunctive treatments to improve quality of life, address specific concerns of the child or family, or modify environmental conditions that may be causing additional problems. Consultation with pediatric specialists may suggest therapeutic options. Discussion of a range of treatment options may avert feelings of frustration and powerlessness that drive families to alternative sources of care.

5. Educate families to evaluate information about all treatment approaches.

Families should be informed about placebo effects and the need for controlled studies. The pediatrician should explain that anecdotal and testimonial evidence is very weak. Families also should be advised to be vigilant for exaggerated claims of cure, especially if such claims are for treatments requiring intense commitment of time, energy, and money on the part of the family.

6. Avoid dismissal of CAM in ways that communicate a lack of sensitivity or concern for the family's perspective.

Some alternative therapies considered by families may warrant independent review and evaluation of scientific merit by the pediatrician. Respectful family-centered care rests on the pediatrician's willingness to listen carefully and to acknowledge the family's concerns, priorities, and fears, including social and cultural factors that may affect their choice of therapies. If CAM is chosen against the advice of the pediatrician, he or she should continue to offer care to the child.

7. Recognize feeling threatened and guard against becoming defensive.

Families may express their opinions in ways that challenge the professional expertise of the pediatrician. They may bring to the discussion of CAM a number of biased assumptions that contribute to an atmosphere of distrust and an adversarial relationship. It may be helpful for the pediatrician to make empathic statements that acknowledge the families' deep concerns, thereby avoiding angry or defensive reactions.

8. If the CAM approach is endorsed, offer to assist in monitoring and evaluating the response.

The pediatrician can help to establish clinical outcomes and target behaviors or symptoms that can be observed and measured. Sometimes, the

pediatrician and family can agree on a time-limited trial of the proposed approach.

9. Actively listen to the family and the child with chronic illness.

The pediatrician should be aware of their concerns, their understanding of the condition, and their needs for support. Support groups and community networks can greatly enhance family comfort with the management of the chronic illness or disability.

COMMITTEE ON CHILDREN WITH DISABILITIES, 2000–2001

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APPENDIX I

Helpful Resources on the Internet

1. University of Texas Center for Alternative Medicine Research, <http://www.sph.uth.tmc.edu/utcarn/default.htm>
2. The National Institutes of Health Office of Alternative Medicine, <http://altmed.od.nih.gov/>
3. The National Council for Reliable Health Information, <http://www.ncrhf.org>

4. The Consumer Federation of America, <http://www.quackwatch.com>

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Divider Title: Micozzi

Bio-Brief of Marc S. Micozzi, M.D., Ph.D.

MARC S. MICOZZI, M.D., Ph.D. is the Executive Director of The College of Physicians of Philadelphia and the Adjunct Professor of Medicine and of Rehabilitation Medicine at the University of Pennsylvania. He was previously the Founding Director at the National Museum of Health and Medicine in Washington D.C., and a Senior Investigator at the National Cancer Institute, National Institutes of Health (NIH). He has published six Books and over 200 articles on medical and health topics. He was the Founding editor-in-chief of the first medical journal on complementary and alternative medicine and is editor of the first textbook, *Fundamentals of Complementary and Alternative Medicine*, now in its second edition. He serves as consultant to the U.S. Federal Trade Commission and the Commonwealth of Pennsylvania Bureau of Professional and Occupational Affairs on complementary and alternative medicine and is Principle Investigator on a grant from the NIH for developing a professional reference resource on alternative therapies in cancer. He has been a frequent speaker to medical and consumer audiences worldwide on complementary medicine.

Testimony Of Marc S Micozzi, M.D., Ph.D.
Executive Director, College of Physicians of Philadelphia
White House Commission on Complementary and
Alternative Medicine Policy
March 27, 2001

Thank you Mr. Chairman and Members for the opportunity to appear before you this morning. In keeping with the theme of today's session, I will primarily address the work of the College of Physicians of Philadelphia through our Division of Public Services and our C. Everett Koop Community Health Information Center. (Koop CHIC). Andrea Kenyon, a distinguished medical librarian and public health leader in Philadelphia, who is with me today, directs the Division.

The College of Physicians is the nation's oldest medical academy founded in 1787 by Benjamin Rush, a signer of the Declaration of Independence, and eleven others in the year of the U.S. Constitution. Today the College is a national center for medical history and operates a national historical library and museum of medicine. One of the most important lessons from the history of medicine in America is that lasting and meaningful advancements in medical practice are ultimately founded on reform of medical education. I think you are all aware of my own work over the past decade to create journals, textbooks and conferences to further medical education in complementary medicine. My sixth national CME conference will take place here in this facility exactly two months from today. Most of the distinguished members of this panel have been and remain valued personal contributors to these efforts. Time does not permit me to acknowledge

you individually; please accept my sincere gratitude and appreciation to you all for your support over the years, as well as your leadership on this Commission.

As you know, it is customary for a person about to testify to provide detailed charts, graphs or other visual aids. Some years ago, at the request of Senator Tom Harkin (D-Iowa), I appeared before a Senate subcommittee with an entire iron lung. This was to help make the point that federal support for biomedical research had been responsible for transforming a formerly essential piece of medical equipment into a mere museum piece.

Today, the one visual aid that I've brought with me is small enough to fit in my wallet. Mr. Chairman, I'm holding up a library card for our C. Everett Koop Community Health Information Center. The Koop Center is a free health information resource which seeks to empower the people of greater Philadelphia and Southeastern Pennsylvania by providing authoritative, timely information on a host of diseases, conditions and health concerns. In communities across the nation, accessing reliable information on complementary/alternative medicine and other health-related topics should be as simple as owning a library card.

The foundation for this development is being established in a unique information alliance being pioneered by the College and the Free Library Philadelphia (FLP). The College has been a strong advocate for improving public health since its founding. The College's membership spans all major medical specialties and represents the gold standard in clinical practice, research, teaching and health care administration. When it

comes to health information prepared for the general public, our members have the knowledge and experience necessary to help decide what is accurate and appropriate.

We take pride in the fact that the Free Library of Philadelphia was actually founded by a physician and a Fellow of the College, Dr. William Pepper. The central branch of the Free Library was founded in 1891. Fueled by support from Andrew Carnegie, library branches soon sprouted in neighborhoods throughout Philadelphia. Today, with 50 branch libraries and 2 million cardholders, the Free Library system constitutes one of the most important networks for the diffusion of knowledge and information in the eastern United States. With a huge client base to draw on and convenient locations throughout the nation's fifth largest city, the Free Library is the right partner to distribute accurate public health information.

The generational cohort born between 1946 and 1957 has transformed America. Blessed with the freedom to make real, substantive choices in housing, education and careers, this group felt that the concept of choice should apply in healthcare as well. They sought alternatives to medical procedures which they perceived as expensive, invasive and increasingly technological in nature. Coupled with a determination to be active partners in the process of protecting their health, and through the power of the market place this cohort forced the nation's healthcare system to change in ways which were inconceivable in 1960.

Complementary medicine has become one of the most significant consumer movements in modern times. Millions of Americans care enough about complementary medical approaches to pay for it out of their own pockets. Patients log more visits to alternative practitioners than to primary care physicians. Once it became clear that complementary approaches were here to stay, the system began to respond appropriately. Different components of the federal government began to conduct clinical trials to test the effectiveness of promising complementary approaches. Medical schools began to educate their students about the history and cultural significance of alternative treatments. Health insurance plans which once shunned complementary approaches as experimental, now sometimes cover them and aggressively market their availability. Sometimes it seems that these approaches have gone from being taboo to the marketing tool of choice in little more than ten years.

Several years have passed since the Food and Drug Administration reclassified the acupuncture needle as a therapeutic device, yet among the many Americans who suffer from chronic pain, too many remain unaware that acupuncture can be an effective, non-addictive means of providing real relief. Time has marched on since U.S. government research concluded that spinal manual therapy provides more effective relief for acute lower back pain than drugs or surgery. Yet, the nation's workers and employers, confronted daily with this most common of all workplace injuries, are not all aware that manual approaches can save them money while providing the relief they need.

You may have read about recent efforts by state legislatures around the country to legislate safety in the school yard. Yet we've known for years that meditation/relaxation techniques associated with traditional Ayur vedic Indian medicine, for example, are effective in reducing tension and stress and aiding academic performance in the schools. We could cite many more examples of the disconnect between the results of clinical research conducted by the federal government and current public practice in many spheres of life in the U.S. What is to be done?

In my experience, those physicians being trained today are often aware of the these facts and can offer appropriate advice to individual patients and institutional clients alike. One problem is that older physicians differ greatly in their awareness of these facts and their willingness to accept them. Perhaps Surgeon General David Satcher might send a letter to the nation's doctors reporting briefly on those complementary approaches which have been validated by clinical research within the last five years.

I also believe that the following statement is true: many local school districts throughout the United States require some form of health education to be taught as part of a student's total education. Let's take a hard second look at what is actually being taught in these classes. In communities where local school boards are open to it, let's begin to teach students (and their teachers) meditation and relaxation techniques. We might also consider including more and better information about the ancient civilizations and diverse cultures which gave rise to these health traditions worldwide.

While we are focused on children, it is important to point out that pediatricians have an interest in complementary medicine although the vast majority of research information is on adults. Nonetheless the wellness and health promotion orientation of most complementary medical systems and modalities provides a natural affinity for much of pediatric practice. Our social view of complementary medicine for children is somewhat paradoxical. On the one hand, complementary therapies are generally gentler, less invasive and often seen as "more natural". They appeal to many parents as approaches to many childhood illnesses especially given the often harsh side effects of conventional treatments in children, which we often seem less willing to accept in children than we do in adults. On the other hand because much of complementary medicine remains untested by the standards of contemporary clinical research, there is natural reluctance to feel like one is experimenting on children with unproven remedies. For many years the NIH Office on Alternative Medicine did not provide funding for pediatric research on complementary medicine, directing their attention to therapeutic modalities and medical conditions in adults. However, the NIH has begun to create research programs specifically focused on children. Also, practitioners in certain fields such as homeopathy, nutrition and manual therapies have been conducting pediatric research on their own.

President Bush, a former Governor of Texas, is a firm believer in the idea that the private sector and the states are the true engines of innovation and experimentation in the U.S. Perhaps one or more states might be willing to offer incentives to employers who start new workplace health and wellness programs which incorporate appropriate

complementary and alternative approaches. These programs may be limited to our Pacific Coast states in the beginning, but if states save as much in workman's comp payments as may be anticipated, other states will choose to participate as time goes on.

At the College of Physicians, our own Koop Center was established for two reasons. Our physician members are acutely aware that while patients want and need to be more involved in caring for their own health than ever before, doctors, responding to the realities of managed care, are now expected to see more patients than ever before. Our goal is to empower patients, by giving them the credible knowledge and accurate information necessary to make the most of the time they do have with their physicians.

Our members and physicians generally, are very concerned about the inaccurate and misleading health information which is currently available on the Internet and commercial sources. This misinformation constitutes a public health problem of its own. This is one reason a growing number of physicians are taking advantage of our "Prescription for Knowledge" program. Under the terms of this initiative, doctors send patients to the CHIC to access additional information on subjects of concern to them. One cornerstone of our system is that a trained medical reference librarian is always present. Although labor intensive, it makes it much easier for patrons to take advantage of the resources that the CHIC offers. You may be interested to know that the U.S. Centers for Disease Control did a year long survey to learn more about the information needs of our patrons. We found that 49% of our respondents wanted information on a specific disease or condition, 20% wanted wellness information, 13% wanted physician

information, 11% had questions about complementary medicine and 8% sought information on specific medications. The CDC evaluation found the CHIC to be the most credible, thorough and accurate source of health information in the Delaware Valley, with the best customer service.

I believe that our developing alliance between a major medical library and a public library system serving a multitude of different audiences with different health information needs should replicated across the U.S. and will constitute a major advance in making credible, timely information about complementary medicine and other health promotion and disease prevention issues available to the broadest possible audience.

Thank you.

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Divider Title: Larson

David B. Larson, M.D., M.S.P.H.

National Institute for Healthcare Research

Dr. David B. Larson is the president and primary founder of the National Institute for Healthcare Research (NIHR), a research-based organization committed to disseminating research on spirituality and health.

Dr. Larson has pioneered the study of spirituality and health. His systematic reviews of the literature in the mid 1980s first brought recognition of the neglect of spirituality in research and clinical health care to the forefront of professional discourse.

Since that time, Dr. Larson has been actively engaged in research activities, amassing more than 250 professional publications. He has also stimulated critical new research that has examined the impact of spirituality on a variety of physical and mental health outcomes including mortality, chronic and serious illness, depression and aging. He has directed seven groundbreaking conferences which have drawn together the nation's leading researchers and educators, and has become a recognized expert on the relationship of spirituality to physical, mental, and social health.

Dr. Larson is a Duke University-trained psychiatrist and geriatrician, as well as an epidemiologist. He formerly served as a senior researcher in the National Institutes of Health (NIH), the Department of Health and Human Services (DHHS), and the Mental Health Services Branch of the National Institute of Mental Health (NIMH).

In addition to presiding at NIHR, Dr. Larson holds academic positions as an adjunct professor of psychiatry and the behavioral sciences at both Duke University Medical Center and Northwestern University Medical School, as well as serves as an adjunct professor of preventive medicine and biometrics at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. He is a Fellow of the American Psychiatric Association and the Southern Psychiatric Association.

Dr. Larson is a frequent resource for the national media on issues surrounding health and spirituality. He has been featured on programs including ABC's "Good Morning America" and "World News Tonight," and in news magazines and the national press that include *Time*, *U.S. News and World Report*, *The Los Angeles Times*, *The Washington Post*, *New York Times*, *The Wall Street Journal*, *Boston Globe* and *USA Today*.

**THE WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE
MEDICINE POLICY, HEARING ON CAM AND WELLNESS**

MARCH 27, 2001

**Testimony of David B. Larson, M.D., M.S.P.H., President of the National Institute for
Healthcare Research (NIHR).**

I would like to thank Commission Chairman Gordon and the other Commissioners for inviting me to participate on this important panel on Complementary and Alternative Medicine in Wellness and Self-Care. My name is David Larson; I am a psychiatrist, outcomes epidemiologist, and President of the National Institute for Healthcare Research, or NIHR, which is a private, not-for-profit research institute focused on analyzing and disseminating published research findings on the relationship between spirituality and physical and mental health and well-being. You might say that I “sort of” stumbled onto this relevant health care factor some twenty-plus years ago, and then continued to study it while working at the National Institute for Mental Health in the 1980’s and have been studying it ever since. In particular, I have been interested in spirituality as it relates to clinical prevention and coping with severe and chronic illness as well as enhancing treatment outcomes, particularly for those who already possess or have strong spiritual or religious beliefs.

I have been asked by the Commission to comment on the relationship between spirituality and health as well as the relationship between spirituality and complementary and alternative therapies. I’ve also been asked to comment on what I perceive to be some of the significant barriers and opportunities to incorporate spirituality into clinical care and to provide recommendations for steps and approaches that can be taken to begin to make spiritual factors a more integral part of health care. So, without further elaboration, I will go directly to these issues.

What is the Relationship Between Spirituality and Wellness?

It would be impossible in the amount of time I've been given to discuss all of the various areas of wellness - whether Physical health, mental health or social health to which spiritual and religious beliefs, practices, and behaviors have been found to be linked.

Oxford University Press recently published The Handbook of Religion and Health (Koenig et al., 2001), which reviews more than ^{12,000} published studies on the relationship between religion and/or spirituality and a variety of mental and physical health outcomes. I will give Dr. Gordon a copy of the book, which I co-authored with Harold Koenig, M.D., of Duke University Medical Center, and Michael McCullough, Ph.D., previously a colleague of mine at NIHR and now at Southern Methodist University, for the Commission to review.

I've chosen to focus on one area in the relationship between spirituality and religion and one substantially illustrative area of wellness -- longevity, or mortality, in other words, the rate of death in a given study or sample population. You might say that, for us epidemiologists at least, mortality is the best, if not one of the ultimate, measure of wellness, in that people who are more susceptible to illness, both physical and mental, will face an increased risk of mortality, or earlier death than those less susceptible. We epidemiologists like to examine potential protective factors for health and risk factors for illness by assessing whether or not they stand up to the test of "mortality analysis." In other words, we like to follow healthy populations over a number of years in a variety of locations and then see if a particular variable, in this case spirituality, predicts a longer or a shorter lifespan.

I'm going to provide you with a brief overview of the spirituality and mortality data. I have submitted a copy of a newsletter NIHR previously published concerning the topic to the Commissioners so that they can review for more details.

Religion, Spirituality, and Mortality

Early findings of an association between religious and/or spiritual factors and death rates, or mortality, were somewhat unexpectedly found. For example, in the early 1970s, Comstock and Partridge (1972) found in an epidemiological study assessing the role of social factors in death rates in nearby Washington County, Maryland, that there was an association between weekly church attendance and significantly lower rates of coronary disease, emphysema, cirrhosis, and suicide. Unfortunately, this study was the first of its kind, and was not followed up for a number of years. Therefore, the results were initially somewhat unnoticed.

However, beginning in the 1980s and then especially in the early 1990's, as the research findings grew at site after site, and the findings and research methods and controls for potential confounders or mediators improved, the results of this early study not only held up, but actually became stronger. Researchers, thus, began to take a much closer look. As a result, in the past few years, a number of large-scale longitudinal studies that *have* dealt specifically with spirituality and religion have continued to reveal a consistent association between a greater frequency of spiritual or religious participation and lowered mortality.

For example, in 1997, Strawbridge and colleagues analyzed the effect between frequent church attendance and mortality over 28 years for 5286 individuals living in Alameda County, California, which would certainly not be viewed as a "Bible Belt" area. This study found that

Alameda County residents who attended church frequently had lower mortality rates than infrequent attenders, and the relationship was stronger for women than for men (Strawbridge et al, 1997). Importantly, factoring in potential mediating factors, such as smoking and exercise, had little impact on this relationship, whereas adjustments for "social connections" reduced the relationship but it still remained significant. The authors concluded, therefore, that mortality rates are lower for frequent church attenders than infrequent attenders and that the lower mortality rates they found for frequent attenders are only partly explained by improved health practices, increased social contacts, and more stable marriages occurring in conjunction with church attendance. Indeed, the same authors found in a recent follow-up study published in the February 2001 issue of The Annals of Behavioral Medicine that frequent worship attenders were in better health at the start of the study, but more importantly, that those who didn't have good health habits to begin with, were more apt to develop healthier habits if they attended church more frequently.

In a 1998 study, Oman and Reed analyzed the prospective association between attending religious services and all-cause mortality among almost 2,000 elderly residents of Marin County, California. The purpose of this study was to determine if there was an association between religion and mortality and, if so, whether it was explainable by 6 potential confounding or mediating factors: (1) demographics, (2) health status, (3) physical functioning, (4) health habits, (5) social functioning and support, and (6) psychological state. This study found that persons who frequently attended religious services had a 24% lower risk of mortality, or premature death, compared to non-attenders (Oman and Reed, 1998). After adjusting for the six potential confounding and mediating variables, this relationship was reduced only slightly, primarily by including the levels of physical functioning and social support. The researchers did not find the

same health benefits when people they followed participated in other community groups, though they did find that attending worship services regularly and volunteering had a complementary effect with those who participated in both activities, living even longer than those who attended worship services on a regular basis.

More recently, Koenig and colleagues (1999) demonstrated a 28% decrease in relative hazard of dying for frequent church attenders compared to infrequent attenders. This finding was once again independent of demographics, health conditions, social connections, and health practices. Demographers Hummer and colleagues (1999) likewise recently analyzed data from the *National Health Interview Survey-Multiple Cause of Death Survey* and found that people who *never* attend church had almost *twice* (1.87 times) the risk of death in the studies follow-up period compared with people who attended church more than once a week. This translated into a clinically important "seven-year difference" in life expectancy between those who never attend church and those who attend more than once a week. The difference in life expectancy was even more dramatic for African Americans: with frequent attenders living on average 14 years longer than infrequent attenders.

Finally, a meta-analysis conducted by McCullough and colleagues (2000), which analyzed data from 42 published and unpublished data sets (representing nearly 126,000 people), found that religious involvement over all was associated with a 29% greater odds of survival (or conversely lower risk of death) for the follow-up periods of the studies with spirituality's effects being stronger for women than for men.

Admittedly, most of the studies I've just cited most frequently used a single-item measure of spirituality, that is, religion and most frequently a measure of worship attendance. However, the finding that frequently attending religious services can make such a consistent difference in life expectancy and one that according to the meta-analysis would take more than 1,400 "no relationship" findings to reverse, suggest that something is going on either during or in between attendance of such services that is keeping these individuals healthier or well. Indeed, something—either one's spirituality or associated activities and behaviors that go along with being spiritual—is helping spirituality or religiously committed people to maintain a more optimal level of wellness, both mentally and physically, and also providing them a higher quality of life in the process.

It should not surprise us that the relationship between religion and spirituality and health, however, is not always a positive one. Indeed, I ventured into this field wanting to follow up on what I was taught during my psychiatric training in the 1970's - that being overly religious was usually harmful to one's mental health. In fact, - there were a few studies at the time and a minority of studies continue to be published that have demonstrated that certain types of spiritual or religious beliefs could be harmful to one's mental health or even physical health.

Nevertheless, the majority of research in this area continues to suggest a beneficial relationship for physical, mental, and social health for those who are more committed to their religious or spiritual beliefs, practice them frequently, and rely on them in their everyday lives. I refer you to the results of a series of NIH type consensus conferences that NIHR sponsored several years ago on the topic. For more details on this body of research (see Larson et al.,

1996), I will also provide a copy of this consensus conference report entitled *Scientific Research on Spirituality and Health: A Consensus Report* to the Commission.

What is the Relationship Between Spirituality and CAM

Turning to the second issue—what is the relationship between spirituality and CAM?—the New England Journal of Medicine and JAMA surveys conducted by David Eisenberg and his colleagues (Eisenberg et al., 1993, 1998) have demonstrated that religious practices such as prayer are among the most prevalent complementary and alternative practices used by people in the United States. Indeed, these and other surveys suggest that as many as one-third to one-half of those surveyed at the least, use some form of spiritual approach to manage or cope with their illness (Koenig, McCullough and Larson, 2001). For example, several recent studies have documented that spiritual practices such as prayer and meditation are some of the most frequently used CAM approaches among cancer patients (Lippert et al, 1999; Sparber et al, 2000) and those facing other serious medical problems (Liu et al, 2000; Larson et al., 1996). The use of spiritual approaches to managing health and coping with and treating illness can become even higher among certain ethnic populations in the United States, such as Hispanics (Keegan, 1996) and Native Americans (Kim and Kwok, 1998; Marbella et al., 1998) as well as among the elderly (Foster et al., 2000, Koenig, McCullough and Larson, 2001). Furthermore, there is a significant spiritual component to many of the systems of medicine that are typically classified as CAM. Most of these traditional systems of medicine--such as Ayurvedic Medicine, Traditional Chinese and Oriental Medicine, and Native American Medicine--place a great deal of importance on the role of spirituality in maintaining health and treating disease.

For example, the fundamental concepts of Traditional Chinese and Oriental Medicine are embedded in the philosophical and metaphysical worldviews of Taoism, Confucianism, and Buddhism, which evolved and spread throughout East Asia over the past 2,500 years. As a result, treatment modalities, such as acupuncture, Qi Gong, Tai Chi, and even herbal treatments, are used to cleanse, strengthen, and circulate the vital life energy (Qi) and blood.

Similarly, Ayurveda, the traditional system of medicine coming out of India that has been practiced for more than 5,000 years, has as its central tenet that disease in the body begins with imbalance or stress in the *awareness*, or consciousness, of the individual. This mental stress leads to unhealthy lifestyles, which further promote ill health. The Ayurvedic practitioner, therefore, uses a variety of precise body postures, breathing exercises, and meditative techniques, all derived from the age-old Hindu discipline of Yoga, to maintain health and prevent illness. In addition, herbal preparations are added to the patient's diet for preventive and rejuvenative purposes as well as for the treatment of specific clinical disorders.

Native American healing practices also do not separate out body, emotions, or spirit in the context of health. This is why so much of the medical care among traditional Native Americans is considered as the wise use of powers and wisdom of plants and animals. Another implication is that spirituality and medicine are combined concepts for Native American practitioners and their patients. Indeed, the term "medicine" as used in English ("medicine woman," "medicine wheel") is usually a translation of various Native terms for "holy" and "power". Traditional Native American approaches to healing, such as "Sweating and Purging" are intended to purify the body as well as the spirit. Finally, Shamanic healing is also a relevant if not important part of nearly all traditional Native American healthcare as well.

What Are the Significant Barriers and Opportunities to Incorporate Spirituality into Healing?

Despite the historical and continuing relevance of spirituality to complementary and alternative medicine and now even conventional medicine, with 70 of 126 medical schools having frequently required courses in spirituality and medicine (Puchalski and Larson, 1998), it is surprising how little emphasis has been placed on this topic in CAM research. The National Institutes of Health is just beginning to fund some small pilot studies in the application of spiritual beliefs and practices in health. NIH funding, however, is chiefly coming from one Institute, the National Institute for Alcohol Abuse and Alcoholism, and these funds do not even approach what is needed to begin to address the potential of this “forgotten factor”, but relevant clinical factor to not only to assist people in maintaining wellness but also to potentially reduce health care costs. To date, NCCAM has spent approximately a “wing and a prayer” in this arena. Although the Frontier Medicine initiative is a step in the right direction, most of those funds, as I understand it, are to be focused on “non-local” healing and intercessory prayer studies, not on the more basic types of studies that are really needed in the prevention, coping and improving treatment outcomes for this frequent “health care factor of choice” for our patients as well as those in the population.

In fact, research studies are beginning to emerge suggesting the mechanisms of how spirituality may aid in maintaining health as well as helping those who are ill to assist in recovering their health. There is evidence that social support, better health behaviors, the promotion of positive emotions (e.g., hope and optimism), the relief of guilt and anxiety, and even better immune functioning, may all play a role in the effects that religious and spiritual factors have on health outcomes (see Koenig et al., 2001, for a review of this literature). Yet, the prospective, longitudinal studies that are needed to demonstrate causality as well as begin to examine the precision of the

mediating relationships of spirituality on health are very expensive to conduct. The small amounts of funds that are currently available from the private foundations already supporting these efforts, including the Fetzer Foundation and the John Templeton Foundation, are not sufficient to face the task. In addition to the need for funding for studies of mediators, there is also a significant need for investigations focused on the role of spirituality in improving care and treatment outcomes supporting illness coping as well as improving the quality of life in those who life-threatening and chronic diseases and disabilities.

Finally, there also is a critical need for better access to information in this field. Indeed, until just a few years ago, studies on religion and spirituality and health were not included in most medical databases since they weren't keyworded even when they contained the word "spirituality" in the article's title. Therefore, most of the studies before the mid-1990s cannot be found in the major electronic databases. Furthermore, even though national databases, such as Medline, do now include keywords on religion and spirituality and include many of the journals that publish articles on this topic, most of the references on this topic are not abstracted. If they are, the abstracts are so meager that they do not tell one much about either the content or the quality of the articles. Also, the references in this area tend to be spread out over a variety of clinical and sociological databases.

A final major obstacle in the integration of spirituality into healthcare and wellness is the skepticism, which I've somewhat jokingly referred to as the "anti-tenure" factor, among many in the medical and scientific communities toward anything that might involve the "R" word (religion) or the "S" word (spirituality). In contrast, a majority of the American population (more than 90%) either describe themselves as religious and/or spiritual and almost three quarters say their spirituality is the most or a very important aspect of their lives and that they frequently utilize spirituality in

dealing with health-related matters. Sadly, as many of my psychiatrist colleagues once believed, many in the medical and research communities still assume that religion and spirituality are most frequently irrelevant or even harmful to one's health. That's not what the research reveals. Most clinical and research leaders remain unaware of the growing body of scientific research on this topic that has found quite the opposite. Indeed, there are now literally hundreds of studies documenting that, for the most part, spiritual beliefs and practices are beneficial to one's health and even can help reduce one's risk of developing a number of serious illnesses. Furthermore, when people do become ill, research suggests that spiritual beliefs patients cope more effectively and recover faster. Therefore, there is a critical need to increase education so that clinical leaders as well as practicing physicians become more aware of this important body of research, to what is going on now in US medical schools with the next generation of physicians.

Recommendations:

Based on the points I have elaborated, I thank the commission for permitting me to provide them with the following recommendations to consider:

-The establishment of a research Center for Health and Spirituality by the National Center for Complementary and Alternative Medicine. Such a Center would help to coordinate the research in the field by:

- providing grants both for basic research studies on studying the mechanisms of how spirituality impacts health
- providing grants for model programs that attempt to integrate this knowledge into clinical practice and can be enabled to research both patient and cost outcomes.

*Whole Health Survey
Faith-based initiative*

-The development of a centralized data base on spirituality and health that would contain not only the many extant and growing number of clinical research studies, but also information on how to obtain funding as well as literature on model care and educational programs and effective strategies for sensitively and ethically incorporating spirituality into healthcare (Post, Puchalski and Larson, 2000). Such a database would go a long way toward bridging the gap between research and clinical application.

-The support for and development of continuing education conferences and other educational materials to help make the clinical and research communities better aware of the research linking spiritual and religious factors to various aspects of health.

-Finally, there remains a critical need for forums where doctors can have the opportunity to interface and interact with clergy, chaplains, and pastoral care professionals, so that clinicians can develop a better understanding of the potentially important role religious professionals play in promoting health and healing. Many of the medical school courses are employing such a model where physicians are closely collaborating with chaplains; the same can be done to assist practicing physicians to realize the importance of a frequently "forgotten" part of the health care team, the chaplain.

In closing, I thank you for requesting me to come and present today. It has been my pleasure to highlight and recommend needed steps in advancing the research-based integration of spirituality, health and well-being.

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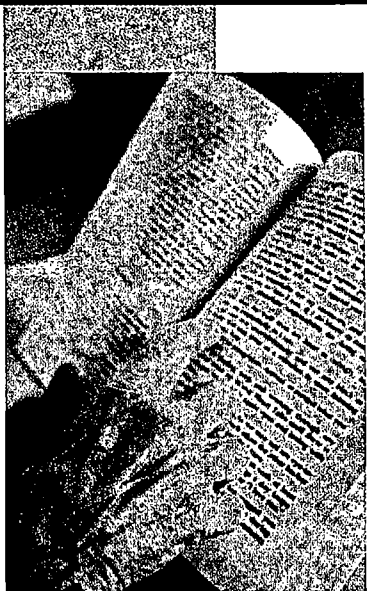
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SPIRITUALITY & MEDICINE CONNECTION®

Volume 4, Issue 2, Summer 2000

RELIGIOUS INVOLVEMENT AND MORTALITY RISK

Robert A. Hummer, University of Texas at Austin
Christopher G. Ellison, University of Texas at Austin



In the last decade, many researchers have found that religious involvement is related to lower risk of early death. Most recently, a meta-analysis identified 42 study samples that investigated the link between religious involvement and some measure of mortality¹ (Please see page 4). Nearly all of the studies on this topic have examined frequency of attendance at religious services (or similar measures of organizational participation)²⁻⁹. A handful

of investigators have considered other aspects of religiousness, such as receiving strength and comfort from religious faith¹⁰. Among the most recent and methodologically sophisticated studies, Strawbridge et al.⁷ found a negative association between frequent religious attendance and all-cause mortality in a 28-year follow-up of residents of Alameda County, CA. This association was only partly mediated by health practices and social ties, and the association was somewhat stronger for women than for men.

Our own work on this topic was recently published in *Demography*⁹. We analyzed data from a nationwide health survey, the 1987 Cancer Risk Factor Supplement of the National Health Interview Survey. Individuals who died between the time of the survey and the end of 1995 were identified through a statistical matching procedure with death certificates. Our study showed that religious attendance is associated with U.S. adult mortality risk in a graded fashion. Notably, people who reported never attending at baseline exhibited 1.87 times the risk of death in the follow-up period compared with people who reported attending more than once a week at baseline. Health selectivity was responsible for a small portion of the religious attendance effect. In other words, people who do not attend church or religious services are also more likely to be unhealthy and, consequently, to die during follow-up. Religious attendance also appeared to work partly through enhanced social ties and improved health practices to decrease the risk of death. Nevertheless, substantial mortality

differences between attendance groups remained, even in the most comprehensive statistical model of all-cause mortality. Further, although the strength of the association between religious attendance and mortality varied by cause of death, the direction of this association was consistent across causes.

With few exceptions², investigators in this area have used predominantly non-Hispanic white samples. The lack of explicit attention to racial and ethnic minority groups is particularly unfortunate given the institutional centrality of religion in several minority communities. We recently sought to fill this gap by closely examining religious involvement and mortality risk among a nationally representative sample of African-American adults¹¹. African-Americans who reported not attending services at all experienced over twice the risk of death in the follow-up period compared to their counterparts who reported attending more than once a week. This differential is larger than what has been shown to exist among the general population of the U.S. Religious non-involvement was linked with a greater risk of mortality for most subgroups (e.g., ages 18-54 and 55+, women and men, southerners and non-southerners) of the African-American population. In most instances, these patterns persisted despite statistical adjustments for a wide range of confounding factors (e.g., sociodemographic variables, SES and health selectivity) and mediating factors (e.g., health practices, social ties and support). It is clear that the relationship between religious involvement and mortality risk should also be examined within other minority populations.

In sum, a number of high-quality studies have shown that there is a substantial relationship between religious involvement and lower mortality risk among the general U.S. population. However, there are a number of issues that remain open for further study. For example, does this relationship work the same way for all race/ethnic groups and for all religious denominational

Continued on page 7



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Cyndi ReiserRD GI Center for
Integrative Medicine

MNT - Medical Nutrition Therapy -

TESTIMONY OF CYNTHIA REESER, MPH, RD, LD ON BEHALF OF
THE AMERICAN DIETETIC ASSOCIATION
BEFORE THE WHITE HOUSE COMMISSION ON COMPLEMENTARY AND
ALTERNATIVE MEDICINE POLICY

March 27, 2001

Good morning. Thank you for this opportunity to provide testimony on behalf of the American Dietetic Association. My name is Cyndi Reeser, and I am a registered dietitian and Lead Nutritionist at the Center for Integrative Medicine and the Women's Health Initiative at the George Washington University Medical Center. The ADA commends the Commission for its work to develop policy recommendations on the complex and often controversial issue of complementary and alternative medicine.

The ADA represents 70,000 food and nutrition professionals who serve the public by promoting nutritional health and well being. The organization is guided by a philosophy to base its work on sound information drawn from peer-reviewed nutrition research and credible sources representing scientific consensus.

The issue of complementary and alternative medicine is of growing interest within ADA. In a recent practice audit, over 50 percent of dietitians reported that they integrate some aspect of nutrition-related complementary care into the services they provide. ADA's Nutrition and Complementary Care Practice Group has grown to nearly 2,500 members who are actively involved in providing educational resources and networking opportunities to members about complementary and alternative medicine. And last year, our Board of Directors identified complementary and alternative medicine and dietary supplements as 1 of 5 emerging areas on which ADA would focus its work.

While the ADA has not issued a formal position statement on nutrition and complementary and alternative medicine, the Association has issued statements on nutritional aspects of CAM, such as dietary supplements and functional foods. Our members generally view nutrition-related CAM therapies as potential components of medical treatment and patient care where qualified health care professionals can work together to provide products and services supported by evidence-based medicine.

ADA believes that patients and public are best served when dietetics professionals actively collaborate with other knowledgeable health care professionals to integrate nutrition with appropriate preventive and treatment strategies. And, ADA believes continuing research is needed to provide the basis for evidence-based practice in all health care modalities.

Dietetics professionals are trained to carefully evaluate the emerging science and to provide consumers with accurate, current advice upon which they can make informed decisions on matters related to food, nutrition and health. In this context, dietitians have the expertise to evaluate scientific evidence about nutrition-related CAM therapies, as well as the skills to integrate appropriate therapies into a patient's overall health management plan. However, to fulfill those roles, registered dietitians must have access to the science behind nutrition products and practices and understand the research related to the psychology and demographics of CAM users.

One of the continuing challenges for healthcare professionals is the lack of information on some CAM practices, including their efficacy, safety, and how they relate to other treatment

modalities. ADA believes it is most important to evaluate each product or practice based on the level of scientific evidence available to support its use. We have science to verify the role of dietetics in conventional medicine and outcomes research to demonstrate the effectiveness of nutrition services provided by registered dietitians. These services include both wellness counseling and disease treatment for existing health conditions and fall within recognized scopes of practice. Where the data demonstrate the effectiveness of nutrition to prevent or manage a disease, that nutritional intervention should be viewed as conventional care.

A good example of evidence-based nutrition care is medical nutrition therapy, or MNT, provided by a dietitian at the request of a physician. MNT has demonstrated benefits, both in efficacy and cost savings, for the management of diseases such as diabetes, renal disease, cardiovascular disease, osteoporosis and cancer. MNT applications range from diet modification for multiple disease states to administration of specialized nutrition therapies to manage a condition or treat an illness or injury. This role was recognized by the Food and Nutrition Board, Institute of Medicine, which recommended that nutrition therapy, upon referral by a physician, be a reimbursable benefit for Medicare beneficiaries and that registered dietitians be reimbursed as providers.

Last year, Congress approved legislation that provides reimbursement for Medicare beneficiaries in need of nutrition therapy for renal disease and diabetes. Expansion of this coverage to provide MNT services to patients with cardiovascular disease and other conditions now is under consideration.

There is also growing science showing the value of good nutrition to prevent or delay the onset of chronic diseases such as cancer, heart disease, age-related macular degeneration and obesity. ADA believes in the power of preventive nutrition and urges greater public awareness of the importance nutritional strategies to support health. The American health care system also should recognize the cost savings of prevention and should provide medical coverage of preventive interventions where the data exist to support it.

Some “nutritional” strategies intended to improve health are not equally well documented and supported in scientific literature. For example, there are varying degrees of evidence to support the safety and efficacy of dietary supplements in the marketplace.

Vitamins, minerals and other nutrients delivered as dietary supplements can play an important role in preventing disease and promoting good health, but they are not a substitute for a well-balanced diet. We know that behavioral changes to enhance nutrient intake for optimal health are best made through diet first and then adding supplements when needed. However, throughout the life cycle, there are times when nutritional needs exceed those typically consumed through the diet.

The nutritive value, efficacy and safety of herbs, botanicals, hormones and some other classes of dietary supplements are not fully known at this time. Despite this fact, their use is considered by most to be within the realm of “nutrition.” This is not to say that these products may not have a preventive or therapeutic role against certain conditions. Many may have strong physiologic effects, and scientific research has revealed phytochemicals that, when delivered in the right amount, have measurable health benefits. As research programs and new supplements enter the market, health care professionals will need to assess the potential safety and efficacy benefits these substances will offer.

In the current environment, the broad definition of “dietary supplements” and high consumer demand has increased the need for dietetics professionals who can help consumers make informed decisions based on sound scientific knowledge. Dietitians are trained to translate research into actionable steps for consumers. Discussing the potential benefits and risks of various interventions is an important role of dietitians and other health professionals.

Dietetic professionals are taught that it is important to understand the perspective of the patient and the reason or reasons that he or she may feel that a particular wellness strategy or treatment modality is beneficial to their health. For example, patients may take dietary supplements to prevent disease, to treat disease, or to improve functions such as stamina, memory or energy level. Sometimes patients turn to supplements because they are dissatisfied with a conventional disease treatment and supplements help them feel more in control of their health. For some patients, dietary supplements are part of their culture.

Communication with patients regarding dietary supplements and other modalities requires healthcare professionals to be open to unconventional remedies and willing to investigate the potential merits and limitations of each. ADA advises that dietetic professionals withhold judgment on the value of a dietary supplement or any other treatment or wellness strategy until the dietitian can weigh the evidence, taking into consideration a patient’s medical history, current use of medications and dietary habits.

Conclusion and Recommendations

To summarize, members of the ADA generally see nutrition-related CAM therapies as potential components of medical treatment and patient care in which qualified health care professionals work together to provide scientifically sound, safe or empirically proven therapies to better serve patient needs. We believe that patients who utilize nutrition-related CAM modalities should receive that care from health providers who have appropriate knowledge, training and expertise to select suitable and appropriate preventive and treatment strategies. We also believe that dietetics professionals are valuable members of the extended team of CAM providers and play an important role in the integration of nutrition with other modalities of treatment.

Scientific data support both preventive nutrition, and medical nutrition therapy as an essential component of a disease management strategy. However, continued research is needed to evaluate fully many CAM practices and to provide the basis for evidence-based practice. Any preventive or treatment strategy, whether considered conventional or CAM, should be supported by sound science and evidence-based practice before being integrated into a health care strategy.

Cynthia Reeser, MPH, RD, LD, is a Research Associate at the George Washington University Lipid Research Clinic and is Lead Nutritionist with the Women’s Health Initiative. She has taught community nutrition classes and is a frequent speaker to the public and media on nutrition topics. For the Center for Integrative Medicine, Reeser offers nutrition counseling with particular expertise in women’s health, cardiovascular disease and diabetes, health promotion and education, and vegetarian nutrition. Reeser has served as a volunteer nutritionist with the Peace Corps in North Africa, and as a nutrition consultant with various programs throughout West Africa. Reeser is a graduate of The Ohio State University and the University of North Carolina. She holds a Masters in Public Health in Nutrition, and is both a licensed and registered dietitian.

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***Nutrition, CAM, and Wellness from a CAM
Perspective
Panel #2 - Integrative Approaches to Wellness:
Nutrition***

**White House Commission on
Complementary And Alternative Medicine Policy
Public Hearing on CAM in Self-Care and Wellness**

Hyatt Regency Washington Hotel on Capitol Hill
400 New Jersey Avenue, N.W.
Washington, D.C. 20001
10:20 - 11:10 a.m. Tuesday, March 27, 2001

Testimony of Michio Kushi

(b)(6)

Dear Honorable Chairman and White House Commission Members,

The Era of Humanity is now beginning. Alternative and Complementary Medicine is one evidence of the processing of this transition from the Modern Age to the New Era of Humanity.

While we are appreciating the development of conventional medical technologies both in diagnosis and treatment, we also know that modern conventional medicine has been largely symptomatic and divisional approaches.

We are also appreciating all various Alternative and Complementary approaches to healthcare, including exercise, breathing, meditation, vibrational and electromagnetic treatments, herbal medicine, supplements, acupuncture,

moxabustion, shiatsu massage, polarity, traditional folk medicine, psychological and spiritual approaches, and various diets.

Diets alone vary from juicing, raw food eating, high protein, vegetarian, high and low fiber, low sodium, and many others; and conventional nutritional theories, with their concept of calories. Some of these approaches, however, while we are appreciating their temporary effectiveness for certain symptoms, still maintain a fragmental view of human life.

The Macrobiotic way of life and its recommended dietary practice are based upon human traditional eating, with natural organic foods and proper cooking, in harmony with the environment, which has been practiced for many centuries in different climactic and cultural adaptations. (A Pyramid form of the Standard Macrobiotic Diet in a temperate climate is herewith attached.) Through this practice in America, Europe, Japan, some Asian countries, and South America, uncountable numbers of people have regained their health, even from terminal sicknesses, and have restored their loving family life and peaceful relations with people and society.

The approach of Macrobiotics is to solve and correct the cause of physical and mental disorders in daily diet and lifestyle. As examples, dietary causes of some disorders are briefly summarized here:

1. CANCER

Because cancer has diversified symptoms, its dietary causes are also diversified. For example:

Prostate Cancer – is caused by over-consumption of heavy animal protein and fat; together with oily/greasy and hard-baked food.

Breast Cancer- is caused by over-consumption of dairy fat and simple carbohydrates, such as sugar, chocolate and honey; together with oily/ greasy food

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Other cancer symptoms are summarized in the attached papers of causes, case histories, and medical research papers related to the macrobiotic diet (which were presented to the House of Representatives Government Reform Committee in June 1999; and the Asian Therapies Conference in March 2001); and in the book *The Cancer-Prevention Diet*.

2. HEART DISEASE

Though there are varieties of symptoms, the major causes are over-consumption of animal protein and fat, as well as hot spices, simple carbohydrates, and oily/greasy food, as detailed more in the book *Diet For a Strong Heart*. The Macrobiotic approach can secure Blood Pressure reduced by 10% from the national average, and cholesterol less than 150 (average for Macrobiotic persons is 126). These were studied already in 1976 by Harvard University Channing Laboratory and the Framingham Heart Study Center. A summary of medical research papers is attached.

3. ALLERGIES

The cause is generally over-consumption of dairy food, stimulants, and simple carbohydrates; as well as oily/greasy food, in various degrees.

4. ARTHRITIS

Several kinds of arthritis can be classified, such as osteo and rheumatoid; but overall, the causes are over-consumption of animal protein and fat, especially poultry, eggs, seafood, and dairy food, together with nightshade vegetables, fruits and fruit juices, simple carbohydrates, and stimulants.

5. DIABETES AND HYPOGLYCEMIA

For both, the underlying cause lies in a pancreatic hormone secretion disorder, which is caused by excessive eating of animal protein and fat, especially poultry, eggs, and cheese. Contributing are heavy baked flour consumption; and simple carbohydrates, stimulants, and oily/greasy food. Please see attached summary of medical research papers.

6. AIDS & VIRUS DISEASE

Decline of natural immunity is caused by over-consumption of sugar, chocolate, and other simple carbohydrates, and refined flour; together with dairy food; tropical fruit and fruit juices; and stimulants.

7. EMOTIONAL DISORDERS

Are caused by irregular eating. Some are more over-consumption of animal protein and fat, such as inwardly depressive paranoia symptoms. While over-consumption of sugar & simple carbohydrates, stimulants and spices, and soft drinks are causing more hyper-activity, excitement, irritability, and schizophrenia.

8. MENTAL DISORDERS

Violence and children's psychological problems, such as Attention Deficit Disorder (ADD) are also caused by their dietary habits, which lack whole grain and vegetables as a major portion of their eating; and by excessive intake of animal protein and fat; sugar, oily food, spices, and stimulants. Please see attached summary of medical research papers, including a reference to the Tidewater Detention Center report.

9. BODY-MIND-SPIRIT RELATION

Mind, Spirit, and Body should not be considered separate. Natural energy is received from the Universe, the Earth, and environment, forming our image, mental and spiritual nature, as well as chakras and meridians. In addition, food also releases energy and vibration, affecting mind and spirit.

Practically all physical, mental and spiritual disorders are caused by our food, our lifestyle, and our environment. Therefore, correction to proper diet, lifestyle, and environment should be the center of any health approach, regardless of CAM or conventional medical approach. Please see the attached diagram, where Diet is at the center of all health and wellness approaches.

We recommend the following as the policy of the United States for Alternative and Complementary Medicine, as well as for Wellness:

1. Allot and distribute available funds for **Research and Education** on the effectiveness of Alternative and Complementary solutions, for both prevention and recovery, with diet and lifestyle as the base. We also recommend a pilot plan for clinical trials in some hospitals and healthcare centers.
2. Establish **Community and School Educational Programs** to recover healthy lifestyles and proper home-cooking, which is whole grains- and vegetable-based: including adult education, and public schools in their home economics or health education programs.
3. Hold **Industrial Conferences** to guide food producers, distributors and servers, including agricultural and marine products.
4. Help facilitate the use of proper diet and wellness plan **in Public Dining Facilities and in Government Programs** such as meals-on-wheels for seniors and in our prisons.
5. Encourage **Hospitals, Clinics, Healthcare Facilities and Medical Schools** to add dietary and wellness studies, counselling, cooking classes, and serving facilities with healthful menus.

6. Apply adequate **Insurance Policies** to support Alternative and Complementary guidance, healthcare and dietary counselling, and learning.
7. Encourage the avoidance of daily consumption of food and water which are overly **Artificialized, Chemicalized, Irradiated**; encourage the proper evaluation of **Genetic Modification**; and encourage more respect for natural, organic, and traditional quality of food and drink.
8. Promote improvements to secure a more **Clean, Natural Environment** of our air, water, and soil; and encourage avoidance of technology which is environmentally harmful.

We would be happy to cooperate with such governmental efforts by participating in research and education, and by dispatching well-experienced macrobiotic educators, counselors, and cooking instructors to any facilities.

These policies would inevitably result in a great turning in the healthcare systems. We need vision, courage, and tireless efforts. On the process of turning, we may face opposition, hesitation, doubt, and misunderstanding. However, to overcome our health crisis, we need to urgently proceed in all domains related to human life. Upon the achievement of this revolutionary turning, America will become a symbol of health, happiness, and well-being for the future of entire planetary mankind.

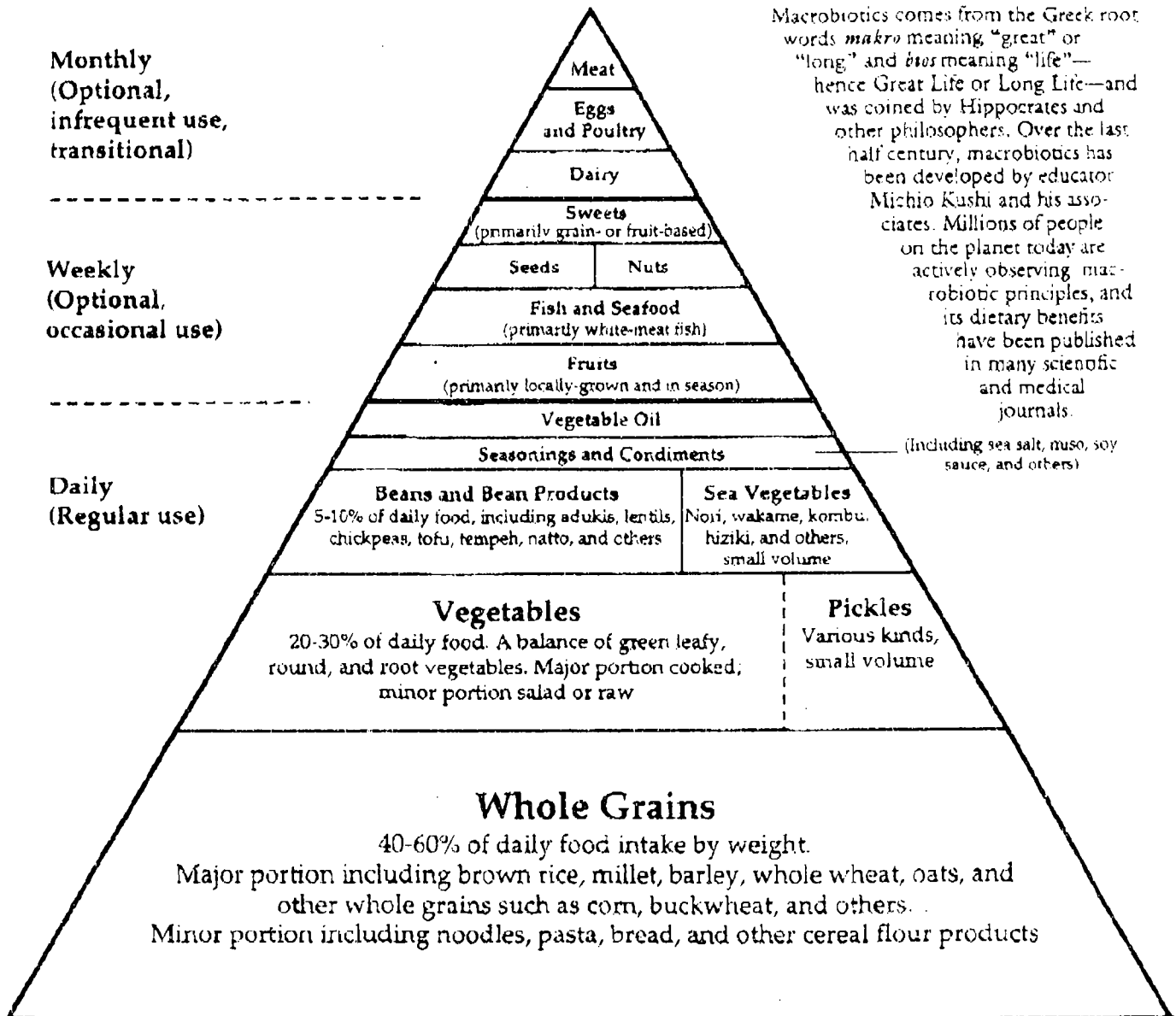
Thank you very much for this opportunity for presenting my humble statement.

Macrobiotic Dietary Guidelines for a Temperate Climate

Macrobiotics

Macrobiotics comes from the Greek root words *makro* meaning "great" or "long," and *bios* meaning "life"—hence Great Life or Long Life—and was coined by Hippocrates and other philosophers. Over the last half century, macrobiotics has been developed by educator Michio Kushi and his associates. Millions of people on the planet today are actively observing macrobiotic principles, and its dietary benefits have been published in many scientific and medical journals.

(Including sea salt, miso, soy sauce, and others)



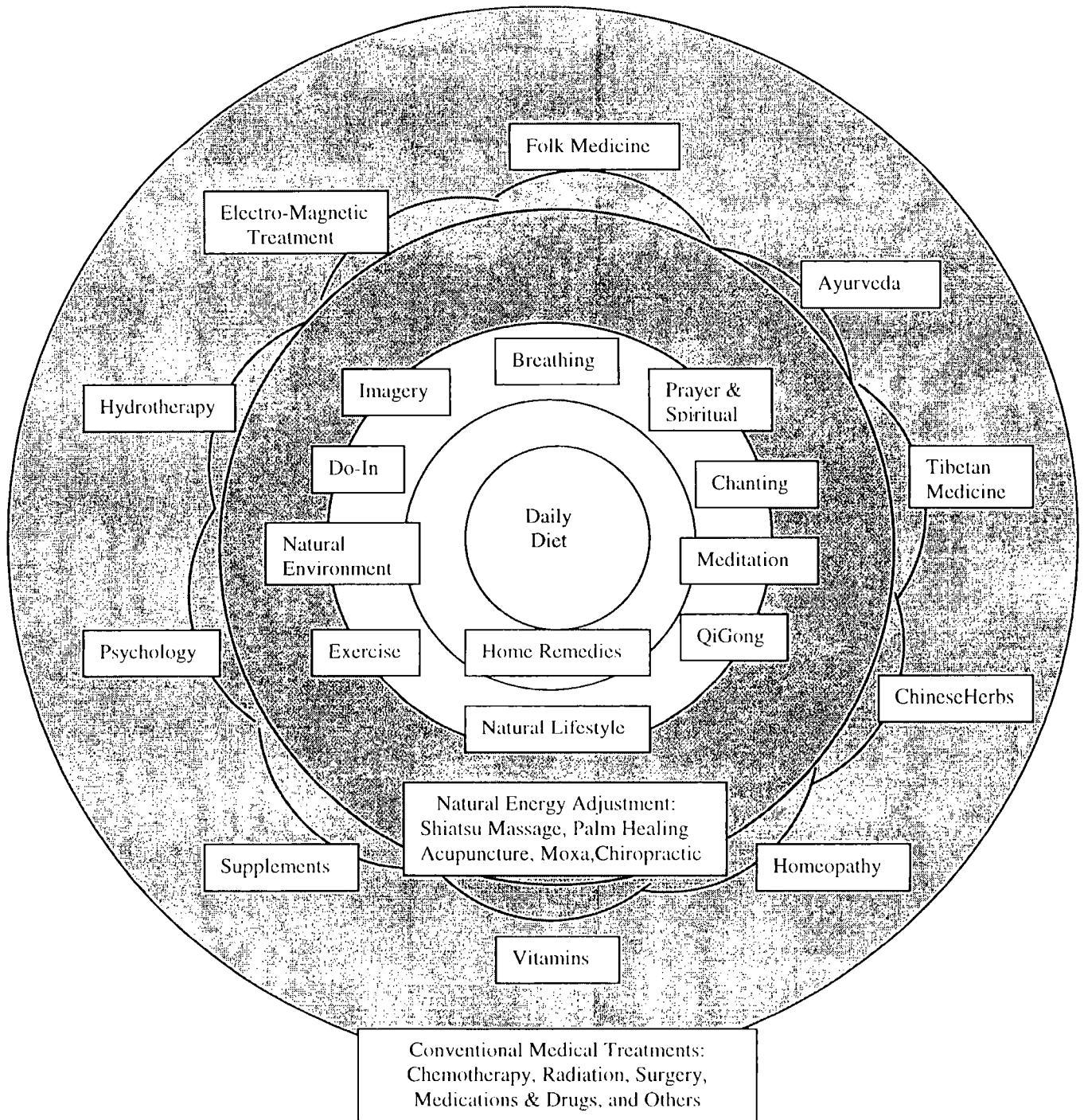
Soup: Grains, vegetables, beans, and sea vegetables may be consumed in the form of soup, 1-2 times daily or several times a week, in addition to the usual styles of preparing these foods

Water: non-stimulant beverages and natural, clean water, including spring, well, or filtered water for drinking and cooking

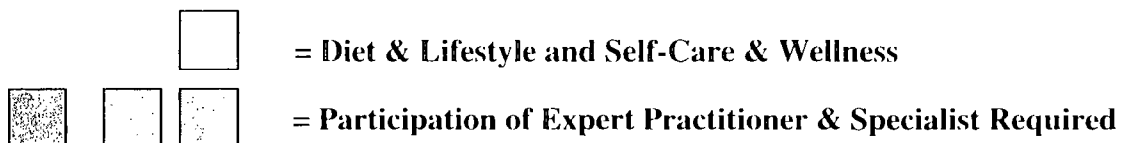
Quality: Food to be natural quality (non-genetically engineered), organically grown as much as possible, traditionally or naturally processed, and prepared using gas, wood fire, or other natural fuel

Note: These are standard averages that may be adjusted for climate and environment, cultural or ethnic heritage, gender, age, activity level, individual condition of health and personal needs, and other considerations

Trial Draft of Overview of Health Approaches



Macrobiotic Overview for Health Approaches, with Macrobiotically-Oriented Diet as the Center of CAM and Conventional Treatments



ADDENDA TO TESTIMONY Of MICHIO KUSHI

Biographical Sketch

Standard Macrobiotic Diet Brochure

Medical Research Papers Summary:

ResearchIndex3.23.01

Heart Disease

Cancer

AIDS

Hypoglycemia & Diabetes

Mental Illness

Alternative Medicine & Diet

Cancer

Summary of Causes

CausesofCancer3.23.01

American Cancer Society

ACSCCommentsOnMBs3.23.01

University of Texas Best Cases

UTXCommentsOnMBs3.23.01

N.I.H. Best Case Series

Grant Overview

NIHGrantRef3.23.01

Index of Cases

SummaryPlus2.01

Summary of 6 Best Cases

SummaryPlus2.01

Diet for a Strong Heart

The Cancer-Prevention Diet

NUTRITION, CAM, AND WELLNESS FROM A CAM PERSPECTIVE
Testimony of M. Kushi

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Research Materials on Dietary Practice for Health Prevention and Improvement

Educational Purpose

**Michio Kushi & Associates
Kushi Foundation, Inc.**

Issued: November 18, 1998

Revised: March 23, 2001

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