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Hyman

Divider Title: _____

Mark Hyman, M.D.

Nutrition, CAM and Wellness: Achieving Optimal Functioning

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Overview

1. Health Promotion vs. Disease Prevention and Treatment. The acute care model is not effective for chronic illness.
2. Nutritional Intelligence is a key element of health creation.
3. What are the educational, research and public policy imperatives that derive from this necessary shift from a disease focused health care system to a health-based model?

The Nature of Health Promotion vs. Disease Prevention and Treatment

Consider this for a moment. How many of us were born with an operating manual strapped to our thigh, an instruction book for the care and well being of our bodies and souls? How many of us know what will make our bodies function optimally, what will give us energy, vitality and longevity? How many of us know what will make us thrive based on our gender, race or age? How many of us truly know what elements of our behavior, habits, diet, exercise, social relationships or spiritual beliefs impede or support our health?

The attainment of this knowledge for each individual is the promise of the revolution in medicine. The revolution spreads through the halls of the laboratory, the hospital wards, the clinic and a new generation of health centers and health resorts. In the pages of our medical journals a new story is being told. The body is one wholly functioning organism. To thrive it must receive the basic elements that give life – essential amino acids, essential fatty acids, specific carbohydrates, fiber, vitamins, minerals, accessory or conditionally essential nutrients, physical and intellectual activity, air, water, light, love, touch and rhythm. Those things that impede our vitality must be identified – anti-nutrients (trans fats, refined sugars, unnecessary food additives, hormones, antibiotic and petrochemical and endocrine disrupting residues in our food supply), inactivity, excessive stress, environmental toxins, infections, isolation, lack of community and more.

revolution, the consumer demand for a new kind of care, and over burdened physicians must give way to a new road map, a compass for navigating the task ahead of us.

My perspective emerges from five years of intensive work and study, testing and treatment within a unique setting -- a health resort. It is a place where people come to promote health and wellness, to work with over 60 health care practitioners – doctors, nurses, nutritionists, exercise physiologists, physical therapists, behavioral therapists, movement therapists, practitioners of homeopathy, traditional Chinese medicine and Aryuveda. Those practitioners interface with hundreds of massage therapists, yoga teachers, qi gong and tai qi teachers, fitness trainers and others. Over 50,000 people per year come through our doors to seek what should be available to a larger population. One quarter of Americans now seek treatment at spas. This is a consumer driven revolution.

Three forces of change in our healthcare system were identified in Price Waterhouse Coopers Report Healthcast: 2010. The first force is the consumer driven shift in demand for a new type of health care and health care delivery system. The second force is the electronic spread of health information and the third is the revolution in genomics and biotechnology that will shift the healthcare system from cure to prevention.

How must we deal with the human and economic burden of nearly 100 million chronically ill people when our health care system is focused on the acutely ill? A recent JAMA article reviewed the status of US Health. "Of 13 countries in a recent comparison, the United States ranks an average of 12th (second from the bottom) for 16 available health indicators." The application of an acute care model to chronic illness creates an enormous burden of suffering (accounting for 225,000 deaths per year or the third leading cause of death after heart disease and cancer) and an economic disaster of $77 billion in extra costs from the adverse effects of outpatient care alone. (JAMA, 2000;284). We are must ask why. We must shift from simply treating disease, to defining, measuring and creating health. (JAMA, 1999;281:1030-1033). We in fact must shift away from the transitional distinctions between complementary, alternative and allopathic medicine to just plain good patient-centered medicine. As William Osler instructed us, "it is more important to know the person who has the disease, than the disease that the person has."

EO Wilson, the Harvard sociobiologist, describes a new ground for the evolution of human knowledge based on "Consilience: The Unity of Knowledge". He outlines the progress from reductionism to synthesis in all disciplines, from the sciences to the humanities. Emerging from the advances in molecular biology, nutritional biochemistry, genomics and proteomics is a new vision – it is the body's little instruction book. It defines health, not disease. A model based on health will supplant the model of health care based on diseases.

Nutritional Intelligence
Optimizing Functioning/Fitting into your Genes

Our public policy and government regulations must reflect "Nutritional Intelligence", a concept that has grown from our work at Canyon Ranch and was given birth by Kathie Swift, our nutrition director.

A local Berkshire educational center, a local school for children who are wards of the state has a clear written nutrition policy. Children less than 12 can have a cheeseburger, small fries and a small coke, and children over 12 can have two cheeseburgers, a large fries and a large coke. We wouldn't feed French fries to our dog. Why do we feed them to our children? The top two vegetables eaten by children are French fries and ketchup.

The USDA reported that the top nine foods eaten by Americans are:

1. Whole cow's milk
2. 2% milk
3. Processed American Cheese
4. White bread
5. White flour
6. White rolls
7. Refined sugar
8. Colas
9. Ground beef

Nutrition is a key foundation for health creation. Conversely, over consumptive under nutrition can cause severe disturbances to our health and accounts for the most of the morbidity and mortality in this country. Food must no longer be seen as simply calories to fuel the body, but information and instructions for the body to achieve health or to promote imbalance and disease. The genomic revolution is converging with the advances in nutrition to disclose the power of nutrient gene interactions. The Pima Indians of Arizona, extensively researched by the NIH, illustrate the power of nutrient-gene interactions in determining health. In one generation they have been transformed from a fit, vibrant, adapted community of desert dwellers to one of the most obese populations on the planet with a rate of diabetes of nearly 80% and a life expectancy of 46. Shifts away from essential fatty acid consumption toward trans fats, and the abundance of refined sugars and a cessation of their physically active life produced the gene expression phenotype of insulin resistance. Nutrition – amino acids, peptides, essential fatty acids, fiber rich carbohydrates, phytonutrients dense foods, vitamins, mineral and accessory nutrients – play a critical role in cell signal regulation, enzyme function, gene transcription, and post-translational modification of gene products --- all critical steps in creating the dynamic balance of physiology and biochemistry that support health.

From the small microcosm of our health care center, I have witnessed the power of nutrition to reverse diabetes, create sustainable weight loss, arrest or relieve chronic

inflammatory diseases including, arthritis, chronic allergy, sinusitis, eczema, food allergy and recurrent infections, reverse lipid disorders, improve cognitive function, relieve depression and anxiety, improve hormonal chaos experienced by women as PMS and menopausal symptoms, end decades of bowel dysfunction from IBS, and dramatically improve fibromyalgia and chronic fatigue. Even in the absence of disease nutrition has the power to improve vitality, function, energy and longevity when combined with improvements in lifestyle.

Implications for Healthcare Policy and Public Health: The Obstacles and the Imperatives

The Obstacles

What are the political, personal, economic and social obstacles to implement the scientific advances of the last half-century connecting nutrition and health? Just as Eisenhower in his final days implored, "beware the military industrial complex", I suggest that the "medical-industrial complex" dangerously impacts our health. It is a loosely defined force of commercial food producers, fast food purveyors, pharmaceutical corporations, health care institutions and the media that unwittingly (or perhaps consciously), contribute to hundreds of thousands of premature deaths and billion's of dollars of preventable health care expenditures. Dr. Willet "estimates conservatively that 30,000 premature deaths per year in the United States are attributable to consumption of trans fatty acids. Because there are no known nutritional benefits of trans fatty acids and clear adverse metabolic consequences exist, prudent public policy would dictate that their consumption be minimized and that information on trans fatty acid content of foods be available to consumers." Am J Clin Nutr 1997;66(suppl):1006S-10S. The obesity and diabetes epidemic is perfectly correlated to the increased consumption of refined sugars that are freely available. The average boy has 36 teaspoons of sugar per day, the average girl 24. The average American consumes half a pound of sugar per day, or 150 pounds per year. The science exists to support labeling our food supply with health warnings, just as we label cigarettes. The economic forces impeding the clear flow of knowledge and science are larger than the tobacco lobby.

In addition to the "medical-industrial complex", a natural resistance to change exists within the medical community. An entire shift in medical education, practice and belief is needed to shift from a disease based model, to a health based model, from the pharmacologic management of disease to methods that uncover the underlying cause of illness and support the body's optimal function and enhance the healing system. How do we encourage practitioners to implement advances in science such as nutritional modulation of cytokines? A recent review in the New England Journal of Medicine highlighted key elements of this approach. The strategy of creating cytokine balance emphasized preventing gut derived endotoxemia, inhibiting TNF alpha activity, inhibiting inflammation, decreasing the production of reactive oxygen species; reduction of liver lipids and improving insulin sensitivity supported the use of "probiotics", herbs, vitamins, "prodrugs" to boost glutathione. (NEJM 2000: 343; 1467-1476) The food we

eat, the substances we ingest, and the phytonutrients and other "pro" substances available to the practitioner today can affect these processes and are supported by peer-reviewed research. There are 500,000 references in the NIH database on dietary supplements. The science of medicine must become the practice of medicine, what we know must become what we do.

The limitations of randomized controlled trials to answer the questions posed by chronic illness have recently come to the forefront. (NEJM). We cannot create a patient centered research agenda as long we focus solely on disease. We must look collectively at the strategies for measuring, and creating new tools to measure the deviations from health, the imbalances and disturbances in physiological and molecular function, and the distortions of cell signaling that precede clinical illness. The single drug, single disease model does not speak to the complexity of biologic function that creates health.

We must consider "prodrugs" rather than "anti-drugs" and study how they can be used to restore normal function in the key systems of the body. For example, insulin sensitivity can be modified by the new class of drugs, the thiozolidinediones, that act on a nuclear receptor (PPAR alpha and gamma) and affect gene transcription. Insulin sensitivity can instead be regulated by nutritional modulation. Trans fatty acids act as analog inhibitors of PPAR, while conjugated linoleic acid (CLA) and the omega three fatty acids EPA and DHA as well as antioxidants act as PPAR agonists. Cell membrane physiology and insulin receptor conformation is also directly affected by the essential fatty acids that form the phoshoplipid cell membrane, as well as specific nutrients including vitamin E, alpha lipoic acid and vanadium. Creatine increases GLUT4 receptors and improves glucose metabolism. Dietary fiber and slowly digested starches modulate intestinal glucose uptake and reduce peripheral insulin production. Strength training and aerobic conditioning also improve insulin sensitivity. From this brief and incomplete description of the effect of diet, exercise, nutrients, essential fatty acids and "prodrugs", it is clear that globally enhancing function can be collectively more potent pharmacologic therapy. It is estimated that 50% of hypertensive patients have insulin resistance as the causative factor. Certain classes of anti-hypertensives (beta- blockers) actually exacerbate the underlying pathology while lowering blood pressure (NEJM). The impediments to integration of this model in health care delivery include insufficient or inappropriate allocation of resources for education of practitioners and the public. Compounding this lack of education is the frequent misrepresentation or misinterpretation of medical information by the media and the influence of marketing by the pharmaceutical and food industries. (NEJM)

Implications for Healthcare Policy

Education of Practitioners

New and innovative strategies must be developed that grow from a cohesive understanding of health, from a synthesis born from many disciplines and fields integrated into a fuller understanding of optimal functioning. The goal of these strategies must be to equip the practitioner, the patient and the media with accurate and clear knowledge of how to care for the human body, how to enhance the web of life to maximize health and vitality.

The educational imperatives before us include the development of a focused medical school and postgraduate curriculum on nutritional and lifestyle management of chronic illness and the creation of health. This must include the principles forming a new theoretical foundation for medical care outlined in the paper by Dr. Jeffrey Bland. These emerging principles include 1) biochemical individuality based on genetic and environmental uniqueness or functional genomics, 2) a patient-centered versus disease centered model, 3) an understanding of the dynamic interaction between the internal and external environment, 4) the complex relationships and connections among physiologic factors and 5) health as positive vitality, not merely the absence of disease.

Specific modules are needed on intake and assessment from a patient centered perspective to elucidate the antecedents, triggers, mediators and effects of illness. The teaching modules must include new laboratory diagnostic and functional measurements of health and imbalance focused on early intervention, non-pharmacological management of illness, use of pro-therapies including nutrition, dietary supplements, herbal therapies, exercise, stress management and environmental therapies. These educational imperatives must filter down to all the allied health professions to prevent a patchwork quilt of complementary therapies that have no cohesive framework for practice.

Education of Children

Three of the most important things in life we do not learn in school: the care of our children, and relationships, the care of our finances, and the care of our bodies. Public schools provide the foundation for future life skills – this should include the way to properly feed, nourish and enhance the body and the mind throughout life, how to prevent future illness that we now know begins in childhood such as heart disease, cancer and osteoporosis. Schools can give the children we entrust to them the operating manual for their bodies.

Education of the Public

Public health campaigns are required to highlight "Nutritional Intelligence" and to dispel myths and misconceptions about nutrition and health. Use of the media, television, Internet, the enrollment of modern sports and entertainment icons in the task of public education is crucial. We grew up believing that eggs cause heart disease, milk is nature's perfect food, and margarine is better than butter. How long did it take for the government to recognize the dangers of smoking and adequately label cigarettes? Perhaps the bag of potato chips, or a dish of French fries, or a can of cola should have a warning label: "this product contains trans fats and sugars that can cause obesity, coronary artery disease, cancer and premature death." How many decades was it clear that folate was critical to prevent heart disease, neural tube defects and cancer before public policy mandated its

addition to our food supply? How many people even today know that folate from food is not absorbed as well as from supplements, or even how much or why they should take extra folate? How long must we wait to synthesize, and deliver the science of health, the operating manual to the public? How many billions of dollars must be spent unnecessarily, and how many lives lost before we act in concert as a scientific community and government?

Research Imperatives

Research must be focused on asking the right questions, independent of economic gain. Allocation of resources to identify cost-effective therapies, global management strategies for chronic health conditions, new systems of health care delivery and outcome-based research are essential to advance knowledge that grows from basic principles. New and innovative nutritional and lifestyle approaches, such as the model developed by Dr. Ornish for heart disease reversal must be applied to other chronic illnesses and studied.

Think tanks and policy centers of clinicians and scientists and policy makers must be convened and funded to synthesize the plethora of data on health, nutrition and lifestyle implications for creating a healthy population. There is often an enormous chasm between information and knowledge. It is time to bring together experts from different fields, from the laboratory and the clinic to create clearer distinctions and a new synthesis that will be the body's little instruction book.

New Models of Health Care Delivery

The days of Norman Rockwell's America have passed. The old doctor patient office visit is today an apparition of what it once was, and though the form remains, it cannot contain the exigencies of today's medical and economic realities. We must explore, define and create new models of health care delivery. These might include group patient visits where physicians can educate 20 people for one hour with common problems, teach self-care, nutrition and provide the tools necessary to reduce dependence on the health care system and pharmacologic treatment of illness. New forms of health centers are emerging such as the Continuum Center for Health and Healing in New York that may serve as model for integrated care. Support for local centers for fitness, nutrition education, cooking and self-care can be provided. Research proven methods for lifestyle modification and education can be employed within existing health care institutions. Reimbursement based on disease or ICD-9 and CPT coding must be revised to reflect the cost savings of a shift from acute or terminal care to early assessment and intervention in the prevention of chronic disease, the enhancement of function and the creation of optimal health.

Health resorts or "spas" can become a resource for education, health promotion and wellness. The European model of government funded six-week visits to health resorts should give us pause, and help us conceive a new type of "healthy vacation" where one is restored, renewed and given the tools to care for the body and mind.

The future of medicine lies in defining, measuring and creating health in individuals and populations, in providing each of us the operating manual for a healthy life. We have an

unparalleled opportunity to shift our health care system from one based on disease to one based on health and open the door to a new era in medicine.

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Medical Director
Canyon Ranch Health Resort
March 27, 2001

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The doctors of the future will prescribe no medicine, but will interest their patients in diet, the care of the human frame, and the cause and prevention of disease.

Thomas Edison

Reductionism is the primary and essential activity of science. Also crucial are synthesis and integration, tempered by philosophical reflection on significance and value...To make any progress [researchers] must meditate on the hidden design and forces of the networks of causation."

E.O. Wilson, *Consilience: The Unity of Knowledge*

The science of medicine is perhaps the most frequently cited case of increasing specialization seeming to follow inevitably from increasing knowledge, as new cures and better treatments for many diseases are discovered. But as medical biochemical research comes up with deeper explanations of disease processes (and healthy processes) in the body, understanding is also on the increase. More general concepts are replacing more specific ones as common, underlying molecular mechanisms are found for dissimilar diseases in different parts of the body. Once a disease can be understood as fitting into a general framework, the role of the specialist diminishes. Physicians...may be able to apply a general theory to work out the required treatment, and expect it to be effective even if it has never been used before.

David Deutch, Ph.D, The Fabric of Reality

...the International Epidemiological Association and the WHO describes two aspects of health: health balance and health potential. Measuring progress in the third public health revolution entails going beyond counting diseases, their indicators, and risk factors. It requires delineating and measuring health in individuals.....Individuals can aim for more than freedom from those physical and mental disturbances that are listed in the disease nomenclature. With equal emphasis, the energy and reserves of health that permit a buoyant life, full of zest and the eager ability to meet life's challenges, should be sought.

***From Disease Prevention to Health Promotion*: JAMA, 1999;281:1030-1033**

This global progress [in medicine] also has allowed more detailed study of the link between basic molecular defects and functional disturbance of processes in cells, organs, and the organism, the so-called "genotype-phenotype correlation". These correlations are often very elusive owing to the many steps in the cascade between cause and effect in the cell and the complex interactions between multiple genes and environmental factors....

The combination of large-scale gene-expression analysis with pharmacological and nutritional studies will ultimately allow the stratification of individuals by their genetically determined abilities for drug and nutrient metabolism. Tailor-made treatments and lifestyle regimens will improve the effectiveness of therapies and reduce side effects. This will apply equally to monogenic disease and more complex gene-environment interaction disorders, like cardiovascular disease, cancer, hypertension, arthritis, migraine, epilepsy, Parkinson's disease, and Alzheimer's disease.

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NUTRITIONAL INTELLIGENCE

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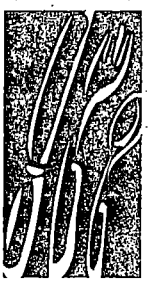


What is Nutritional Intelligence?

It is the Canyon Ranch philosphy that integrates practical food and nutrition knowledge with an understanding of yourself. Developing your nutritional intelligence can lead to long-term eating strategies that work for you.

A balanced approach to eating energizes the body, stimulates the mind and enriches the spirit.

GUIDING PRINCIPLES OF NUTRITIONAL INTELLIGENCE

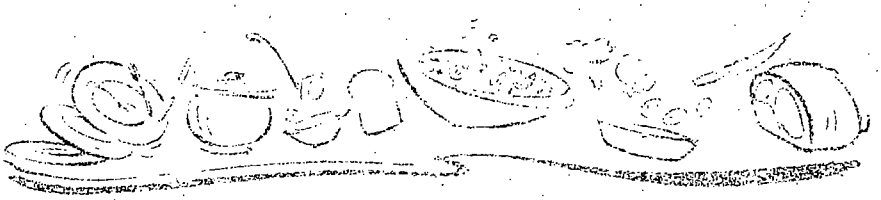
Honor your individuality
Your nutritional needs are your own. Many factors influence nutrient requirements – genetics, health and medical history, eating preferences, lifestyle and more. Your eating experiences are closely connected with your natural ability to make food choices that reflect your uniqueness.

Enjoy the sensual and social aspects of eating
Maximize your enjoyment of food by indulging your preferences for flavor and texture, and by treasuring the social pleasures of the table. Include pleasant conversation and create meaningful mealtime rituals. Eating should be a joyful experience that engages your physical and emotional senses. A meal with family or friends nourishes both body and spirit.

Consider the balance of your meals
Choose a variety of foods, including generous amounts of vegetables and fruits, moderate amounts of protein-rich foods and whole grains, and small amounts of healthy fats and oils. A balanced approach to eating energizes the body, stimulates the mind and enriches the spirit.

Eat to gently satisfy your appetite
Establish a pattern of eating regularly throughout the day to avoid extreme hunger. Learn to moderate your portions by eating with awareness and attention to your physical appetite.

Focus on clean and wholesome food
Choose fresh, seasonal vegetables and fruits, and foods free from preservatives, additives, hormones, antibiotics and other unnecessary chemicals. Shop for natural foods and discover great tastes and the rewards of supporting a cleaner and safer environment.



HOW TO EAT INTELLIGENTLY

Begin by assessing personal needs or goals
Consult with a nutritionist to identify your nutritional needs. A nutritionist can guide you toward the diet that is best for you, derive nutritional meaning from lab tests, and evaluate types and amounts of supplements that may be important. A nutrition counselor will work with you to develop your healthiest relationship with food.

Establish a pattern of eating regularly
Nourish your body by eating regularly throughout the day to avoid extreme hunger. Try to eat every three to five hours. Work toward a pattern of breakfast, lunch and dinner with an afternoon snack, if necessary – especially if there is a long time between lunch and dinner. It's easy to forget to eat during a busy day, but regular meals may help you cope better with a demanding schedule.

Be mindful of portion sizes
Enjoy generous amounts of vegetables, and choose moderate portions of protein-rich food, starches, side dishes and fruit. Learn to stop eating when your hunger is satisfied, and work on distinguishing between physical hunger and other reasons for eating such as stress, anxiety, boredom and emotional hunger. Develop strategies for eating out – share entrees or order a salad and appetizer. Remember, you're more likely to be satisfied with reasonable portions if you don't let yourself become ravenously hungry between meals.

Eat 8 to 10 servings of vegetables and fruit daily
These foods have the most power to prevent disease. Make major improvements in your diet by finding at least three new ways to conveniently add vegetables and fruit to your daily routine. Consider adding fruit to your breakfast, enjoy a medium-to-large salad once a day, be sure that each meal includes vegetables and/or fruit, and always include fruit or vegetables in your afternoon snack. Finally, choose organic produce whenever possible to minimize pesticide exposure.

Emphasize whole grains
Whole grains provide fiber and help stabilize blood sugar levels for several hours after eating. Other great carbohydrate sources include beans, sweet potatoes and pasta cooked al dente. Try hummus and other bean spreads, lentil and pea soups, and vegetarian chili. Learn how to prepare whole grains like quinoa, barley, and brown and wild rice.

Eat 8 to 10 servings of vegetables and fruit daily

Focus on healthy fats and oils

Fat is an essential part of a healthy diet. Canyon Ranch recommends a range of 20 to 30 percent of calories from fat for most people, and an emphasis on those fats with a positive impact on health. In the last few decades we've learned a great deal about dietary fat, and many people have become frustrated by seemingly conflicting information. The latest word? The *type* of fat you consume may have more impact on your health than the amount.

The *type* of fat you consume may have more impact on your health than the amount.

- **Emphasize monounsaturated fats found in extra virgin olive oil, canola oil, avocado, olives and nuts.** Dress your salads lightly with an olive oil vinaigrette, using a delicious variety of vinegars or citrus juices. Sauté vegetables in olive oil and garlic. Eat small amounts of nuts each day and add avocado slices to sandwiches and salads.
- **Include a daily source of omega-3 fat in your diet.** Omega-3 fats protect against heart attack and reduce inflammation. They're abundant in oily, deep-water fish, and in nuts and seeds. You can get more omega-3 fat by adding freshly ground flax seeds to breads and muffins you bake at home, and by using fresh walnuts or pumpkin seeds on salads, in sauces or as snacks. Try eggs that contain higher amounts of omega-3 fat in the yolk, and enjoy fish – especially deep-water varieties such as salmon and sardines – several times a week.
- **Avoid trans-fat (hydrogenated oils).** We now know that trans-fat is as unhealthful as saturated fat from animals. Avoid using regular margarine as a spread or shortening when cooking; emphasize fats that are liquid at room temperature instead. When you shop for baked or packaged goods, be on the lookout for hydrogenated or partially hydrogenated oils in the list of ingredients. If you see "hydrogenated" on the label, make another choice: Create consumer demand for healthier products in the supermarket. Also, keep in mind that many fast foods – especially those that are fried – are loaded with trans-fat.
- **Minimize saturated fat.** Choose low-fat or fat-free dairy products like milk, yogurt and traditional low fat cheeses such as feta, chevre and part-skim mozzarella. Choose skinless chicken breasts and the leanest, best-trimmed cuts of red meat. Limit your consumption of foods made with butter and cream, and reduce your use of butter and full-fat cream cheese as spreads. Experiment with substitutes for full-fat dairy products in recipes.

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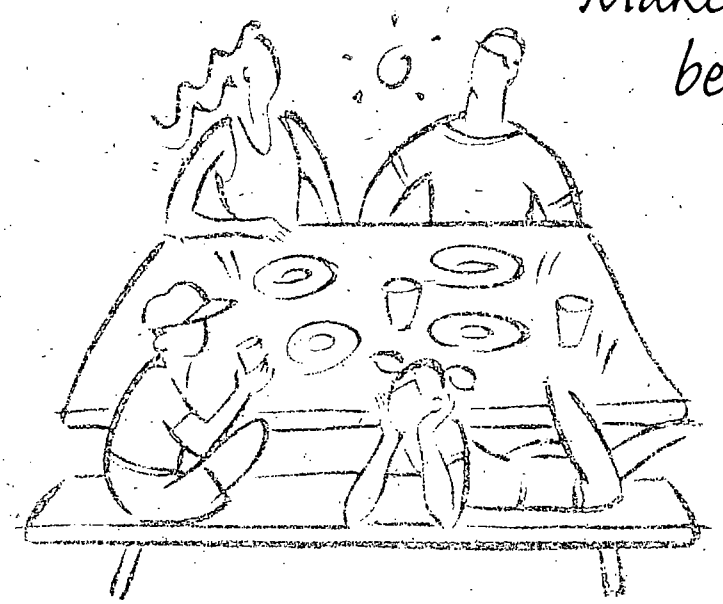
Balance meals with some protein-rich food
Include a protein-rich food with each meal to help control hunger and cravings, and stabilize energy levels. Our favorite sources of protein are beans, soy foods and fish, but there are many other plant and animal foods that can satisfy your protein needs. Don't overlook nut butters, low-fat or nonfat yogurt and cheeses, eggs and poultry.

Limit sugar in your diet and avoid artificial sweeteners
Savor the natural sweetness of whole foods such as fresh fruits, vegetables and nuts. If you must sweeten, go natural with small amounts of maple syrup, honey, brown rice syrup or natural sugar. Choose fruit for dessert, and stir fresh fruit or all-fruit preserves into plain yogurt for a quick breakfast or snack. You can also "sweeten" foods with cinnamon, vanilla and freshly grated nutmeg. Read labels to identify foods that are sweetened artificially, which inflates the desire for extreme sweetness.

Be sensible about salt
Gradually cut down on salt while pampering your palate with delectable, healing herbs and spices. These additions enhance the flavor of food while gently working their restorative magic. Rosemary is calming; cinnamon warms; ginger and chiles add pizzazz. Salt is also a flavor enhancer, but using it in moderation enhances your health.

Drink plenty of clean water every day
Your body is approximately 60 percent water. Because water is continuously used in nearly every life process, it's crucial to keep replenishing the supply. Proper hydration is also important for energy and hunger management – eight large glasses a day is a good rule. Make water your beverage of choice. Install a water cooler in your home or office, and use a beautiful, large tumbler as your glass. Add ice if you like, and a slice of lemon or lime to jazz up the flavor of nature's best beverage.



Make water your beverage of choice

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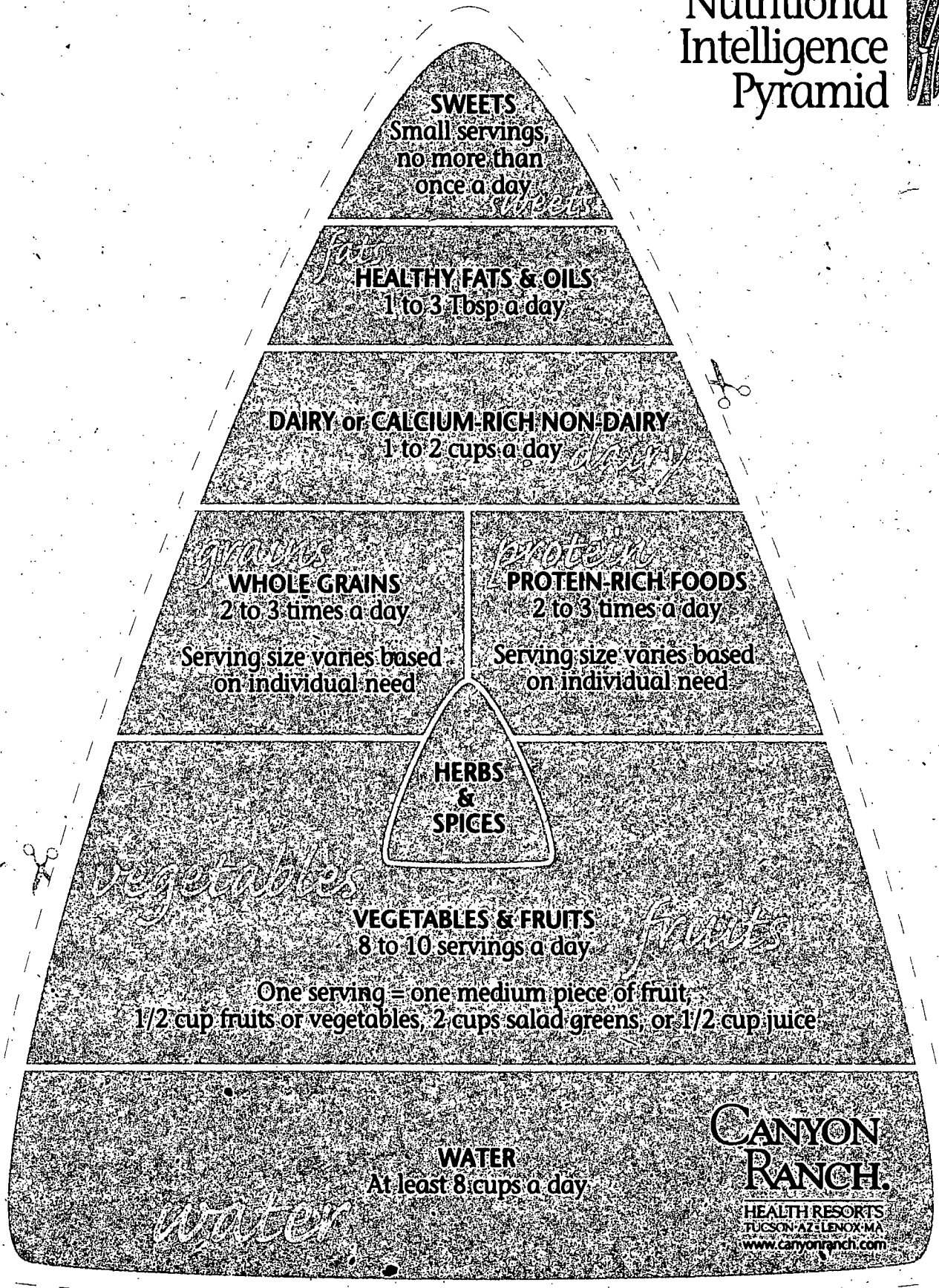
Nutritional Intelligence Pyramid



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Nutritional Intelligence Pyramid

SWEETS

made from fresh, whole foods, especially those with fruit or nuts

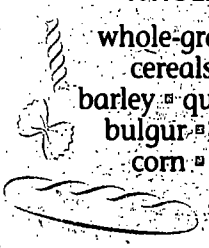
HEALTHY FATS & OILS

olive oil ▫ olives
seeds, especially flax & pumpkin
avocado ▫ nuts

DAIRY or CALCIUM-RICH NON-DAIRY

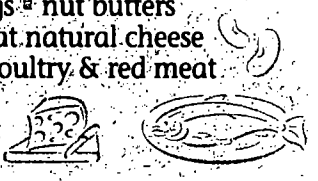
low-fat or nonfat milk
yogurt
fortified soy milk

WHOLE GRAINS



whole-grain breads, cereals & pasta
barley ▫ quinoa ▫ millet
bulgur ▫ brown rice
corn ▫ wild rice

PROTEIN-RICH FOODS

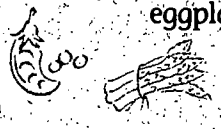


fish ▫ legumes ▫ soy foods
eggs ▫ nut butters
low-fat natural cheese
lean poultry & red meat

HERBS & SPICES

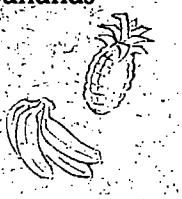
ginger
rosemary
turmeric

VEGETABLES



leafy greens ▫ tomatoes
onions & garlic ▫ asparagus
cruciferous vegetables
root vegetables
green peas ▫ squash ▫ green beans
cucumbers ▫ peppers ▫ mushrooms
eggplant ▫ celery

FRUITS



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citrus ▫ melon ▫ tropical fruits
stone fruits ▫ bananas
juice

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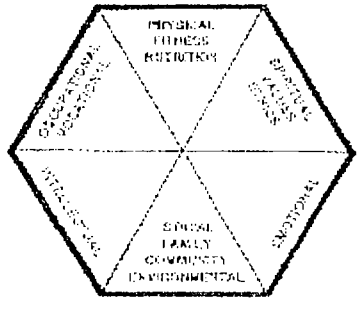
Mission

The mission of the National Wellness Institute is to serve the professionals and organizations that promote optimal health and wellness in individuals and communities.

We accomplish this mission by:

- Providing professional education
- Furnishing information and resources
- Developing and distributing wellness-related products and services
- Providing national and international leadership
- Promoting the adoption of a community-wide culture of wellness in all communities
- Providing specific national spokespersons for key aspects of wellness
- Locating partners to promote the wellness message

Our perspective is global and futuristic. We are committed to the promotion of optimal well-being and operate from the following six-dimensional model.



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Vision Statement

The vision of the National Wellness Institute, Inc. is to promote (1) the understanding of the dynamic factors that contribute to health and well-being as they emerge through research and practice, and (2) the sharing and development of strategies to positively influence those factors that support a worldwide population with healthy, balanced lifestyles.

To promote the understanding of the dynamic factors that contribute to health and well-being as they emerge through research and practice, the National Wellness Institute will provide educational programs and materials that demonstrate the:

- Opportunities and challenges provided by the exponential growth of technological advances.
- Socio-economic, family, and cultural forces that shape the behaviors, attitudes, and beliefs that influence lifestyles.
- Importance of the interconnectedness of not only the body, mind, and spirit, but of the individual with their family, community, and environment.
- Differences among people and validate the strength found in this diversity.
- Emerging research in mind/body/spirit and the applications for providers.

To promote the sharing and development of strategies that have the ability to positively influence the dynamic factors that support a worldwide population with healthy, balanced lifestyles the National Wellness Institute will:

- Provide training on effective methods to encourage individuals to take responsibility for their health and well-being within the support network of their medical, social, and educational systems.
- Provide certificated training programs for professionals in the areas of health behavior specialists, social health behavior specialists, online wellness specialists, and family wellness systems specialists.
- Create and distribute a family wellness system complete with resources for professional and lay use to enhance the health and well-being of families.
- Facilitate learning and networking opportunities for professionals in health care, service and industry, government agencies, educational institutions, communities, and private consultants that will enable them to engage in interdisciplinary, cooperative, and creative initiatives.
- Educate health care professionals on the interconnectedness of the mind, body, and spirit.
- Assist personnel in the health care field with the integration of the art and the science of healing. By including the power of supportive relationships and nurturing of the spirit along with technology, research, and treatment we can create effective and balanced health care practices.

NWI@NationalWellness.org (715) 342-2969 Fax (715) 342-2979
Last modified: Friday January 19, 2001

Wellness in Academics

The Wellness Department at the University of Denver is committed to incorporating wellness and self-responsibility into the culture of higher education. Academically, our mission is to provide information about courses in which students can learn, experience, and live the modern concepts of wellness. There are many classes on campus that embody these concepts; therefore, we act as a resource to identify those courses. The department's philosophy is to promote the education of the whole person (emotional, social, intellectual, physical, spiritual, and community).

Course Listings

Philosophy of Wellness

- 3 quarter class, 2 credit hours per quarter for a total of 6 credit hours. Each quarter focuses on some of the six elements of wellness (i.e. students may study spiritual and physical wellness in Fall, followed by emotional and community wellness in Winter, etc.) Students delve into the inner-workings of the self--from physiology to spirituality. Classes may include the study of relaxation techniques, human diversity, or basic nutrition. Readings are assigned during the quarter, and a final paper or project is required. The class is open to all students, regardless of major or minor. All three quarters are required for the Wellness Minor (see below).

For more information, contact Kristin Ream, Student Wellness Program Director at 303.871.3834.

THE WELLNESS MINOR

- The minor promotes exploration of the mind, body and spirit through study of the six components of Wellness: emotional, social, intellectual, physical, spiritual, and community. The minor consists of **25 credit hours**. Thirteen of those credit hours will be fulfilled with required courses. The other 12 of those credit hours should be selected in consultation with an advisor, from a list of electives.

    - *Students are strongly recommended to take NATS (Concepts in Biology OR Molecules to Humankind) and SOCS (Foundations of Psychology) Core before beginning the minor. Please note: these courses DO NOT count toward the minor but provide a solid foundation for the minor's required and elective classes.*

    - *Required & Elective Courses*

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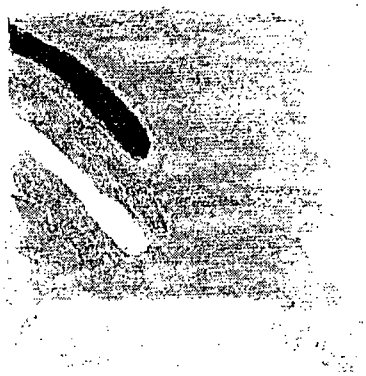

Welcome to WellnessWeb

Mission

"Let every eye negotiate for itself and trust no agent." -- Shakespeare.

WellnessWeb is a collaboration of patients, healthcare professionals, and other caregivers. Our mission is help you find the best and most appropriate medical information and support available.

You'll find information about clinical trials, community health, drug dosages and compliance, treatment options and research, how to select a health care provider, reports on dozens of illnesses and conditions, tips about healthy lifestyles, complementary treatment alternatives and options, and many more topics.

We think patients-consumers should have more input into the delivery and future of healthcare. We're trying to put the HEART back in health care, and hope you'll join us by making *WellnessWeb* a hub of activity.

Why not create a bookmark now?

The Patient's Network - A Community

WellnessWeb was founded by patients when we discovered how difficult it is to become well enough informed to communicate with our doctors. The patients and professionals who are developing *WellnessWeb* look forward to your help

experiences with it.
Thank you.

and feedback. Your participation will create a thriving virtual community, a place to exchange information, support, and gossip.

The Whole Patient

Although most of the information on *WellnessWeb* is based on scientific disciplines like peer reviewed journal articles and double blind studies, we think patients need a broader view. Alternative persuasions will increasingly also be covered.

These two sides of medicine aren't incompatible. Some widely accepted conventional practices have yet to be proven effective, and when quality of life is considered, some even leave the patient worse off from crippling side effects.

On the other hand, although many--probably most--alternative practices haven't been scientifically studied, they may add to quality of life even if they aren't effective for the condition they're prescribed for. We're forming alliances with practitioners of alternative (complementary) medicine with the hope that we can help reduce the noise level and hype, and find what's useful, in this important but chaotic area of medicine.

Our objective at WellnessWeb is to help you make decisions based on your own individual case and lifestyle. The final decision is yours, but the information you get here and elsewhere should be used in conjunction with, not as a substitute for, the advice of your doctor.

Stress Control and Recuperation

You don't need clinical trials to prove that having fun is healthy. *WellnessWeb* has a "stress control" section called *BE HAPPY BE WELL* with pages like "Therapeutic Pets" and "Health Care Capitol of the World" (Philadelphia), and links to the best WWW sites we've found about stress relieving topics like sports, travel, movies, and other therapeutic diversions.

Hint When you click on a hyperlink, you may catch the ailment called "surfing the Web" and forget your mission. It happens to us all the time. So we've learned to use the BACK button. It's in the toolbar of most browsers and acts like a "return trip ticket" to the preceding page. Without the Back button, it's easy to wind up in some remote corner of cyberspace and forget to eat, take your pills, or get to doctor appointments on time.

How Do We Financially Support WellnessWeb?

To help us continue to offer the highest quality information that is in the best interests of patients and consumers, we will accept selective sponsorships and educational grants from health care and other companies to help them create awareness about their products.

Educational grants give us absolute editorial control. For sponsorships, we may create specific client oriented pages within WellnessWeb. These pages will be clearly identified with a legend to the effect that 'this page is sponsored by . . .' When we link WellnessWeb to external sites of sponsorship clients, we will note to the effect that the link will take you to the site of a sponsor of WellnessWeb.

We also try to be highly selective about the products we choose as sponsorship candidates. WellnessWeb is first of all "The Patient's Network" and in that regard, as with other content, we want to bring attention only to products that are in the best interests of patients.

For comments about this policy or information about an educational grant or sponsorship relationship, please send us an email.

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Naturopathic Medicine Center Director:
Dr. Bradley Bongiovanni, ND

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An Interview with Dr. Ira Denton

Resources

- Online Cancer Consultation Center
- The American Association of Naturopathic Physicians
- American Preventive Medical Association is the political voice for health care practitioners who use nutritional and other complementary therapies in patient care.
- The British Medical Acupuncture Society was formed in 1980 as an association of medical practitioners interested in acupuncture. There are now 1500 members who use acupuncture in hospital or general practice. Additionally there are sections for dentists and vets. The BMAS opposes

experiences with it.
Thank you.

unfounded therapeutic claims and recommends the practice of acupuncture by healthcare professionals.

- Center for Mind-Body Medicine
- Complementary and Alternative Veterinary Medicine
- Desert Canyon Treatment Center - A whole-person approach to the treatment of addiction. (See Article)
- Discussion Groups
- Food and Drug Administration
  FDA regulates products that account for 25 cents of every dollar spent annually by American consumers, and touches the lives of virtually every American every day.
- HealthInform publishes a monthly newsletter on alternative healthcare.
- Herb Research Foundation is a non-profit educational facility that has been educating the world about the benefits of botanical medicines for over 16 years.
- Macrobiotics information at Cybermacro
- Find a certified Massage Therapist in the American Massage Therapy Association's Directory
- Native American Healing provides information about herbal remedies, holistic healing, and other alternative methods for keeping the body, mind and spirit healthy.
- Natural Healers -- Educational resource for people interested in studying natural healing arts, such as massage, acupuncture, and naturopathy. Information on schools, programs, and certification and licensing requirements.
- Natural Land is one of the leading sites in healthy natural living with the most thought provoking content, daily breaking news from around the globe, interactive discussion forums, and thousands of pages devoted to the exploration of health, gardening, cooking, nutrition, fitness, weight loss, healing, organic living, herbs, and more.
- New Mexico Academy of Healing Arts in Santa Fe is a Bodywork school offering certification programs in Massage, Ortho-Bionomy®,Somatic Polarity® and Cranial-Sacral. Comprehensive Continuing Education program. Mindfulness and service are at the heart of the Academy.

- The National Center for Complementary and Alternative Medicine
- Text Book of Natural Medicine -- Bastyr Institute
- Yoga for the Special Child

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Mindful Practice

Ronald M. Epstein, MD

Mindful practitioners attend in a nonjudgmental way to their own physical and mental processes during ordinary, everyday tasks. This critical self-reflection enables physicians to listen attentively to patients' distress, recognize their own errors, refine their technical skills, make evidence-based decisions, and clarify their values so that they can act with compassion, technical competence, presence, and insight. Mindfulness informs all types of professionally relevant knowledge, including propositional facts, personal experiences, processes, and know-how, each of which may be tacit or explicit. Explicit knowledge is readily taught, accessible to awareness, quantifiable and easily translated into evidence-based guidelines. Tacit knowledge is usually learned during observation and practice, includes prior experiences, theories-in-action, and deeply held values, and is usually applied more inductively. Mindful practitioners use a variety of means to enhance their ability to engage in moment-to-moment self-monitoring, bring to consciousness their tacit personal knowledge and deeply held values, use peripheral vision and subsidiary awareness to become aware of new information and perspectives, and adopt curiosity in both ordinary and novel situations. In contrast, mindlessness may account for some deviations from professionalism and errors in judgment and technique. Although mindfulness cannot be taught explicitly, it can be modeled by mentors and cultivated in learners. As a link between relationship-centered care and evidence-based medicine, mindfulness should be considered a characteristic of good clinical practice.

JAMA. 1999;282:833-839

www.jama.com

REFLECTION AND SELF-AWARENESS help physicians to examine belief systems and values, deal with strong feelings, make difficult decisions, and resolve interpersonal conflict.[1,2] Organized activities to foster self-awareness are part of many family medicine residency programs[3] and some other residency[4,5] and medical school curricula.[5-8] Exemplary physicians seem to have a capacity for critical self-reflection that pervades all aspects of practice, including being present with the patient,[9] solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values.[10]

This process of critical self-reflection depends on the presence of mindfulness. A mindful practitioner attends, in a nonjudgmental way, to his or her own physical and mental processes during ordinary everyday tasks to act with clarity and insight.[11-15] This article first describes the nature of professional knowledge, competence, and values and then presents current thinking about the philosophical, psychological, and practical aspects of mindfulness. It also explores how mindfulness is integral to the professional competence of physicians and suggests ways to cultivate mindfulness in medical training. In doing so, however, I recognize that *mindful practice*, although supported by empiric observation of clinical practice,[16-21] educational research,[22-26] philosophy,[11,27] and cognitive science,[11,28-30] is fundamentally personal and subjective.

See also pp 830 and 881.

Consider a situation that I recently faced with a patient who required an expanded view of professional knowledge and mindful reflection to achieve a satisfactory resolution. A 42-year-old mother of 2 small girls, despondent over job difficulties, was contemplating genetic screening for breast cancer as she approached the age at which her mother was diagnosed as having the same disease. Aside from the difficulties in taking an evidence-based approach to assigning quantitative risks and benefits to the genetic screening procedure (How much should I trust the available information?) and uncertainty about the effectiveness of medical or surgical interventions (Would knowing the results make a difference, and, if so, to whom?), the case raised important relationship-centered questions about values (What risks are worth taking?), the patient-physician relationship (What approach would be most helpful to the patient?), pragmatics (Is the geneticist competent and respectful?), and capacity (To what extent is the patient's desire for testing biased by her fears, depression, or incomplete understanding of the illness and tests?).

For me, book knowledge and clinical experience were insufficient. I had to rely on my personal knowledge of the

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Table 1. Professionally Relevant Awareness and Knowledge

Levels of Awareness
Tacit (subsidiary awareness)
Explicit (focal awareness)
Types of Knowledge
Propositional
Personal
Process (including metaprocessing)
Know-how

patient (Is she responding to this situation in a way concordant with her previous actions and values?) and myself (What values and biases affect the way I frame this situation for myself and for the patient?) to help us arrive at a mutual decision. These reflective activities applied equally to the technical aspects of medicine (How do I know I can trust the interpretations of medical tests?) and the affective domain (How well can I tolerate uncertainty and risk?). An attitude of critical curiosity,[31] openness, and connection[17,32,33] allowed us to defer the decision and reconsider testing once the immediate crises had passed.

Explicit and Tacit Knowledge

Clinical judgment is based on both explicit and tacit knowledge.[34-36] Medical decision making, however, is often presented only as the conscious application to the patient's problem of explicitly defined rules and objectively verifiable data.[34,37,38] This form of explicit knowledge can be quantified, modeled, readily communicated, and easily translated into evidence-based clinical practice guidelines.

Seasoned practitioners also apply to their practice a large body of knowledge, skills, values, and experiences that are not explicitly stated by or known to them.[34] This knowledge may constitute a different kind of evidence, which also has a strong influence on medical decisions. In everyday life, examples of tacit knowledge abound. Riding a bicycle involves judgments about speed, orientation, and position that are rarely made conscious except when something goes amiss. Similarly, an experienced neurologist can recognize Parkinson disease within moments of meeting a patient, before processing the objective and subjective data to support it. During this preattentive processing,[39] the brain rapidly scans a wide array of perceptions, detects conspicuous features, and relegates some information to the background, all before the content of the perception is analyzed. Clinical skills, such as the depth of insertion of an otoscope, the manipulation of the fetal head during a delivery, and the realization that the patient has given sufficient information to diagnose major depression involve tacit knowledge and preattentive processing.

While explicit elements of practice are taught formally, tacit elements are usually learned during observation and practice.[40] Often, excellent clinicians are less able to articulate what they do than others who observe them. Nor do they appreciate all of the biases in their own reasoning processes.[41] *Subsidiary awareness*[35] is a term that describes how the practitioner makes accessible the flow of unprocessed experience and tacit knowledge.

In the words of Anais Nin, "We don't see things as they are, we see things as we are."[42] Evidence-based medicine offers a structure for analyzing medical decision making, but it is not sufficient to describe the more tacit process of expert clinical judgment.[43] All data, regardless of their completeness or accuracy, are interpreted by the clinician to make sense of them and apply them to clinical practice.[44] Experts take into account messy details, such as context, cost, convenience, and the values of the patient.[36,43,45,46] Physician factors such as emotions,[47] bias,[48] prejudice,[49] risk-aversion,[50-53] tolerance for uncertainty,[54,55] and personal knowledge of the patient also influence clinical judgment.[50-55] Most of the processes described above remain relatively unconscious to the practitioner.

Clinical judgment is a science and an art.[36] Even those who are uncomfortable with the notion of tacit knowledge recognize that it is impossible to make explicit all aspects of professional competence.[43] Evidence-based decision models are very powerful tools, but clinicians do not always use them, especially in complex situations.[30,56] Information necessary to construct explicit models is frequently incomplete or conflicting. Some important tacit knowledge about the patient, such as personality, simply does not fit into predefined categories. To clinicians, these models may resemble computer-generated symphonies in the style of Mozart—correct but lifeless.

Professional Knowledge and Self-awareness

Eraut[57,58] defines 4 types of professionally relevant knowledge, each of which can be tacit or explicit (TABLE 1). The most familiar is propositional knowledge, or what most people call fact: theories, concepts, and principles, usually acquired from books, electronic media, or instructors. Self-awareness of what one does not know and the appreciation for the transient nature of facts can direct ongoing learning.

Knowledge acquired through experience, or personal knowledge, is a collection of information, intuitions, and interpretations that guides professional practice.[35] Consider the following example. Returning from vacation, I saw one of my patients who was infected with human immunodeficiency virus and said to the resident caring for him, "Mr Charles looks worse. Looks like he might have adrenal insufficiency." The personal knowledge exemplified in this scenario differs from an anecdote because it is contextualized. I can say that Mr Charles looks worse because I know him as a person, not just because I know about him, and because I recognize a pattern of disease (weakness and skin color change). This knowledge enters into my mind in an inductive, impressionistic way, providing the gestalt or feel of a clinical situation in addition to the propositional facts.[29] However, confusion between personal knowledge and anecdotal information results in both being neglected and discounted during medical training. An example of the uncritical application of a decontextualized anecdote is when a physician who after

missing a diagnosis of colon cancer, subsequently overtests all of his patients. In contrast, if he had raised tacit personal knowledge to awareness, it could have been subjected to critical reflection.

Process knowledge is knowing how to accomplish a task,[59] such as gathering information, performing procedures, making decisions, and planning for the future.[58] Process knowledge also includes metaprocessing, or the process of reflection on one's own mental processes. This is particularly important in practice, because "we do not observe nature as much as we observe nature exposed to our method of questioning."[60] Metaprocessing might be called thinking about thinking or feeling about feelings. It is both a concrete action (such as the modification in a trajectory of light in a mirror) and an act of self-observation in which the mind attends to its own actions (including the subject who is performing those actions). Metaprocessing allows the physician to uncover areas of unconscious incompetence,[61] the blind spots wherein a physician might not know his or her deficiencies. Fortunately, clinicians can often readily identify these blind spots and gain insight into the influence of the observer, for example, when they review their own videotaped patient visits.[62,63]

Eraut's fourth type of professionally relevant knowledge, know-how, is knowing how to get things done. A resident working in a new setting may know that a diagnostic test is important, but may not know that the test will happen sooner with a friendly call to the radiologist. Learning the steps necessary for getting something done is important in professional development of physicians, but it is often relegated to the informal[64] or hidden[24,26] curriculum.

Mindful Practice

Mindfulness is a logical extension of the concept of reflective practice.[1,12,14] The mindful practitioner is present in everyday experience, in all of its manifestations, including actions, thoughts, sensations, images, interpretations, and emotions.[12,13,65] Mindfulness "leads the mind back from theories, attitudes and abstractions . . . to the situation of experience itself,"[11] which prevents us from "falling prey to our own prejudices, opinions, projections, expectations" and enables us to free ourselves from the "straightjacket of unconsciousness."[66] Mindfulness is attending to the ordinary, the obvious, and the present. Johann Sebastian Bach is reported to have said, when asked how he found melodies: "The problem is not finding them, it's—when getting up in the morning and out of bed—not stepping on them."[67]

Although mindfulness is a practice that derives from a philosophical-religious tradition,[12,14,15] the underlying philosophy is fundamentally pragmatic[13] and is based on the interdependence of action, cognition, memory, and emotion. These connections represent a relatively new idea in neuroscience research.[28,68] Western approaches to the understanding of mental processes have historically separated mental activity from action in the world, and the schism between behavioral and psychodynamic psychology has reinforced some of this separation. However, in the East,[11,14] and in phenomenological traditions in the West,[27] philosophy has linked cognition to emotion, memory, and action in the world.

The goals of mindful practice are to become more aware of one's own mental processes, listen more attentively, become flexible, and recognize bias and judgments, and thereby act with principles and compassion (TABLE 2). Mindful practice involves a sense of "unfinishedness,"[31] curiosity about the unknown and humility in having an imperfect understanding of another's suffering. Mindfulness is the opposite of multitasking. Mindfulness is a quality of the physician as person, without boundaries between technical, cognitive, emotional, and spiritual aspects of practice.

Mindful practitioners have an ability to observe the observed while observing the observer in the consulting room. This process, not often discussed in medical practice, is considered essential to musicians, whose task is to perform and listen at the same time,

Table 2. Characteristics of Mindful Practice

Active observation of oneself, the patient, and the problem
Peripheral vision
Preattentive processing
Critical curiosity
Courage to see the world as it is rather than as one would have it be
Willingness to examine and set aside categories and prejudices
Adoption of a beginner's mind
Humility to tolerate awareness of one's areas of incompetence
Connection between the knower and the known
Compassion based on insight
Presence

attending simultaneously to the technical challenges, emotional expression, and overall theoretical structure of the music.[69] The accomplished musician performs midcourse corrections of finger movements, compares the sound produced with the imagined sound, and, at the same time, brings expressive spontaneity to the performance. However, if the musician were to attempt to control each finger movement while simultaneously analyzing the harmonic structures, rhythms, and silences that constitute expressive playing, playing would become impossible. Thus, focal awareness on the music is accompanied by subsidiary awareness[35] of technique and analysis—a mix of peripheral vision and semiautomatic action that is highlighted only when the unexpected or difficult occurs.

In medicine, consider what a resident in a busy pediatric emergency department might do when he is unable to determine whether an ear examination is normal or abnormal and the attending physician is not immediately available. The resident has several options, consideration of which could be conscious or unconscious. The resident weighs the consequences of misdiagnosis for the patient, the humiliation of having to call an otolaryngology resident out of the clinic, the loss of self-esteem by having to admit incompetence, and the pride in being strong enough to admit his need to learn. An unmindful practitioner who is conscious of the dilemma might judge or blame himself or others. He might base

his course of action on an external standard of correctness or on expedience. However, little would be learned, and he would be no better prepared for the next situation. A mindful conscious approach would be to cultivate awareness not only of the correct course of action but also of the factors that cloud the decision-making process. The mindful practitioner is mentally and technically better prepared for the next situation.

The object of mindfulness can apply to any aspect of medical practice and within any domain of tacit or explicit knowledge. Intrapersonal self-awareness helps the physician be conscious of his or her strengths, limitations, and sources of professional satisfaction. It helps the individual avoid blind spots, such as a physician who, because his or her parent was an alcoholic, avoids discussions of alcohol with patients. It may clarify deeply held values and motivations for becoming a physician. Interpersonal self-awareness, or social intelligence,[70,71] allows physicians to see themselves as they are seen by others and helps to establish satisfactory interpersonal relationships with colleagues, patients, and students. Awareness of metaprocessing allows physicians to be aware of their own clinical reasoning, including the necessary connections between cognition, memory, and emotional processing.[28] Self-awareness of learning needs allows physicians to recognize areas of unconscious incompetence and to develop a means to achieving their learning goals.[61] Ethical self-awareness is the moment-to-moment cognizance of values that are shaping medical encounters. Technical self-awareness is necessary for self-correction during procedures such as the physical examination, surgery, computer operations, and communication.

Often reflection is prompted by a critical incident involving an error, a difficult situation, or an unexpected result of one's actions.[25,72,73] At other times, reflection is prompted by the maturing of an idea rather than by a discrete external event. However, many of these events go unnoticed by all but the most creative thinkers. The discoveries of penicillin, radiation, and the benzene ring were not accidents, but rather the result of someone making what had been considered an outlier (a tainted Petri dish) into data (a useful medication).

Mindfulness enables the practitioner to use a wider set of perceptual resources. The fluidity of mind that can maintain some constant subthreshold awareness of preattentive and subsidiary processes has been described as a "beginner's mind."[12] A beginner's mind is open and allows for new diagnostic and therapeutic possibilities, as may happen when a patient meets a new physician. By contrast, the expert's mind narrows possibilities, using prior experience to delimit and confine observations. Langer[13] describes mindfulness as a state of "could be," welcoming uncertainty rather than trying to avoid it. Difficult patients might then become interesting patients; unsolvable problems might become avenues for research. Critical curiosity shows the limits of categories and helps create more meaningful ones. For example, the recognition of panic disorder as a common cause of chest pain might help physicians recategorize these patients from symptom amplifiers[74] to patients with a serious and treatable illness. Expertise is often well served by beginner's mind, especially in new, unfamiliar, or stressful situations.

Mindfulness implies examining the relationship between the knower and the known as suggested in the "I-Thou" relationship of Martin Buber[75] or the "connected knowing" of ideas, people or things, suggested by Belenky and colleagues.[33] Knowledge, then, does not exist independently but rather in relationship to the one observing and using it. Theories are seen as fragile approximations rather than reality itself.[76] Suchman and Matthews[17] have described this as the *connexional* dimension of medical practice, in which there is a tacit bond between patient and physician that transcends professional roles.

Mindlessness: Gaps Between Knowledge, Values, and Actions

Physicians make moment-to-moment value-laden decisions that entail cognitive and emotional factors. They decide how much effort to expend in pursuit of knowledge, how much pain medication to prescribe, how much time to spend with each patient, and when to return patients' telephone calls. These rapid decisions, usually based on personal knowledge, level of skill, efficiency, and values, ultimately result in actions. Thus, objectives for the practice of medicine calling on physicians should include the ability to perform or knowledge about important aspects of medical care[77] as well as the requirement to actually use those practices in daily work.

Self-knowledge is essential to the expression of core values in medicine, such as empathy, compassion, and altruism. To be empathic, I must witness and understand the patient's suffering and my reactions to the patient's suffering to distinguish the patient's experience from my own. Then I can communicate my understanding and be compassionate, to use my presence to relieve suffering and to put the patient's interests first. Perhaps lack of self-awareness is why physicians more often espouse these values than demonstrate them[78-81] and why they tend to be less patient-centered[82] and confuse their own perspectives with those of the patient[1,80] in situations that involve conflict and strong emotions.

Curiosity is central both to caring about the patient and to solving problems.[83] Fitzgerald[16] describes a trainee who reported a patient as having had a history of "BKA" (below-the-knee amputation) without noting that the patient, in fact, had both feet. A transcriptionist had mistranscribed DKA (diabetic ketoacidosis) and the assertion went unchallenged. The student's lack of curiosity, or overconcreteness, led to mistaking the chart for the patient. Similarly, caring requires an interest in the patient as a person rather than as an abstraction of disease.[84,85] For example, Stetten[18] described how his physicians were uninterested in his adaptation to blindness while they attempted to treat his macular degeneration; they saw the disease but not the person.

Mindlessness accounts for many deviations from professionalism, which seem to occur more often in emotionally charged situations, during situations of uncertainty, and under pressure to resolve problems. For example, many medical students and residents, and presumably practitioners as well, report findings that were not observed and do not seek correction for errors.[20] Actions diverge from professional knowledge and values because of attempts to be efficient, a desire to please supervisors, feelings of embarrassment, and a sense of being overwhelmed.[2,19,21,82,86,87] Practitioners may not think to apply knowledge gained in a classroom context (such as an ethics course) in a stressful clinical environment. Deviations often involve avoidance of difficult issues, rationalization, externalization, or frank denial rather than the healthy processing of emotional feelings toward patients.[88,89]

Levels of Mindful Practice

To guide physicians' professional development, I would like to propose 5 levels of mindfulness, each of which subsumes the previous level and is subject to verification in future observational studies (TABLE 3). At the extreme of mindless practice, the practitioner's response is denial (level 0). By making the problem "out there," the practitioner may avoid responsibility and reflection or describe the situation (or the patient) in ways that are contrary to the evidence.

Level 1 describes practitioners who do not necessarily use reflection but take some responsibility for the situation and solve it by conforming to an external standard of behavior. For example, a practitioner might deal with his attraction to a patient by reciting a rule, such as "sexual intimacy with patients is wrong," but may not seek understanding of the factors that put physicians at risk for misconduct.[86]

Level 2 describes medical decision analysis based on the assumption that explicit cognitive models guide physician behavior and the key to change is the transfer of information. While curiosity and reflection are required to generate hypotheses and important questions, physicians at this level ignore personal knowledge, tacit knowledge, and emotions. Level 3 includes curiosity about feelings, thoughts, and behaviors without attempting to suppress or label them as good or bad. By including emotions and personal knowledge, the clinician has more tools available to promote patient care. Level 4, insight, has 3 facets: understanding the nature of the problem, understanding how one attempts to solve it, and understanding the interconnectedness between the practitioner and the knowledge that he or she possesses.[15] Insight facilitates the calibration of mental processes, in addition to correction of the external problem. Finally, practitioners at level 5 can use their insight to generalize, overcome similar challenges in the future, incorporate new behaviors and attitudes, express compassion, and be present.

Table 3. Levels of Mindfulness

Levels	Characteristics
0	Denial and externalization
1	Imitation: behavioral modeling
2	Curiosity: cognitive understanding
3	Curiosity: emotions and attitudes
4	Insight
5	Generalization, incorporation, and presence

Becoming Mindful

Recent articles[1,5,90] have described a variety of ways for becoming more self-aware. Individually, practitioners might keep a journal, practice meditation, review videotapes of sessions with their patients, and use learning contracts. In medical education, self-evaluation forms for students and residents have been important adjuncts to the evaluation process. Learners can compare their perceptions with those of a teacher or mentor. Peer evaluations have been useful in bringing awareness to aspects of professionalism and social skills for students, residents, and practicing physicians.[91,92] Critical incident reports written by practitioners about mistakes,[20,93] impairment,[94] ethical dilemmas,[95] and difficult situations can be discussed in small group settings and raise awareness about common situations and one's reactions to them. Sharing of family information and cultural background, using genograms or illness narratives, can help practitioners learn about the expectations, biases, strengths, and tendencies that influence clinical care.[96-99] These approaches, historically focused on the emotional aspects of medical practice and the patient-physician relationship, usually consist of exercises separated in space and time from actual clinical practice. Mindfulness training goes one step further. It applies to all aspects of practice, from looking up references to performing physical examinations, from tying sutures to giving bad news.

Mindfulness can link evidence-based and relationship-centered care and help to overcome the limitations of both approaches.[37,43,100] The success of evidence-based approaches depends on the ability of the practitioner to decide which issues require further investigation and how to frame a question. These, in turn, require that the practitioner identify his or her own biases and the influences of the patient-physician relationship on framing of the question to investigate. This personal knowledge should also be considered a form of evidence and could be integrateded into decision making to incorporate patients' preferences. Evidence-based data that are not specific to one patient-physician relationship would then be applied in a more mindful way.

Seminars about difficult topics such as HIV management, delivery of bad news, medical mistakes, professionalism, and adherence to treatment can foster reflection and raise practitioners' awareness of their own emotions and biases, while, at the same time, attending to the practicalities of the patient's problem.[101,102] However, the ability to reflect in a classroom environment is not equivalent to reflection in a stressful clinical environment. For example, ethics courses might increase students' knowledge base and improve their ability to solve difficult problems, but ethics courses do not necessarily produce physicians whose be-

havior is more ethical than it would be otherwise. Clinician-mentors can help students put ideas into action by modeling a moment-to-moment awareness of their own knowledge and emotions that inform their decisions when values are on the line. Professionals can learn to articulate their personal knowledge by observing their own actions (How do I respond to uncertainty? How do I present risks? How do I self-correct when doing a difficult technical procedure?) Professional knowledge is defined, then, not by its validity, but by how it is used.[23]

There is an inherent paradox in teaching or writing about mindfulness. The teacher's task is to invoke a state of mindfulness in the learner, and, thus, the teacher can only act as a guide, not a transmitter of knowledge. In a recent example of a resident about to face a dreaded follow-up visit with an angry patient who thought that earlier treatment of his hepatitis C might have prevented his end-stage cirrhosis, the mentor's role was complex. He had to help the resident identify his feelings of guilt and defensiveness that might interfere with communicating effectively with the patient, determine the risks and benefits of liver transplantation, and explore the patient's wishes regarding end-of-life care. The mentor's approach was to help the resident identify how he psychologically prepares for each visit with a patient, a "centering" process that had been previously tacit, which usually is not explicit for most practitioners, and to use it more effectively. The mentor helped the resident observe himself, effecting a transition from unconscious incompetence to critical reflection and allowing him to come to a satisfactory decision with the patient based on both objective evidence and personal knowledge.

Barriers to mindfulness are numerous in medical training, even in reformed curricula. Fatigue, dogmatism, and an emphasis on behavior (rather than on consciousness)[103] close the mind to ideas and feelings. Unexamined negative emotions lead to emotional distance and arrogance. McWhinney identified 3 additional barriers: unexamined negative emotions, failure of imagination, and literal-mindedness (I. R. McWhinney, MD, oral presentation, London, Ontario, October 6, 1995). Failure of imagination limits the curiosity that is the first step in any process of inquiry. Concrete literal mindedness may serve simple diagnostic processes well, but impedes creative problem solving and limits the physician's view of the patient. Lack of opportunities to learn how to become mindful in practice and the lack of forums to deal with fears and anxieties create further barriers. Finally, some clinicians may fear that mindfulness is the same as excessive self-absorption that would delay necessary clinical actions. They would need to be educated that navel-gazing is antithetical to mindful practice, which has as its goal clarity and attention to the tasks at hand.

Conclusions

Mindfulness, critical reflection, learning, and patient care all "begin with the self as the first, but not the only, object of knowledge."[104] Mindful practice extends beyond examining the affective domains and involves critical reflection on action, tacit personal knowledge, and values in all realms of clinical practice, teaching, and research. Mindfulness is a discipline and an attitude of mind. It requires critical informed curiosity and courage to see the world as it is rather than how one would have it be. Mindful practitioners tolerate making conscious their previously unconscious actions and errors. The goal of mindfulness is compassionate informed action in the world, to use a wide array of data, make correct decisions, understand the patient, and relieve suffering.

Mindful practice requires mentoring and guidance. Recognition of one's limitations and areas of incompetence can be emotionally difficult and can invite avoidance in even highly motivated practitioners. Although mindfulness is an individual and subjective process, each of us can identify practitioners who embody these attributes, learn from them, and identify unique ways of being self-aware. Educators can take on the task of helping trainees become more mindful by explicitly modeling their means for cultivating awareness.

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Just being

> The secret of the care of the patient is caring for the patient
>
> *Care of the Patient*
> F PEABODY, 1927[1]

> The secret of the care of the patient is caring for oneself while caring for the patient.
>
> *Medicine and the Family: A Feminist Perspective*
> L CANDIB, 1995[2]

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SELF-CARING AND SELF-KNOWLEDGE

Caring for oneself, like caring for others, is not always a simple matter. This is because caring always involves knowing.[2,3] I am not speaking of *knowing about*, the accumulation of details that constitute medical records and life stories; these descriptors do not necessarily lead to caring. However, *knowing* does, through a deep appreciation of how experiences, desires, and dispositions contribute to daily actions.

For me, the most fruitful means for self-knowledge have been music and meditation. I hesitate to subsume either under the category of self-care or well-being, as I believe that neither discipline should be limited by having to have an end result. Not that end results are unimportant—Plato and the neo-Platonists regarded music, for example, as having aspects that were essential for moral education and reflection as well as entertainment, and the Pythagoreans regarded mathematics and physics as subdisciplines of music.[4] More recently, studies indicate that music education alters brain structure and function,[5,6] and may enhance learning.[7,8] But I do not—and should not—learn to play a Bach fugue just because it improves my problem-solving skills or makes me feel well. There is more—an element of dedication, engrossment, and relationship with the task that is part of the purpose. So, when I learn a Bach fugue, I transmit both the beauty and structure of musical expression while creating relationships among the music, the audience, and myself.

MEDITATION

In 1971, I took a daylong course in Transcendental Meditation. The turmoils of adolescence during a turbulent era made advertisements promising inner peace very appealing. Although some of the exotic trappings were a bit much for me, the inner process was engaging. I started a meditation practice to begin each day. I left college temporarily to become a student of Zen Buddhism. Part of the reason I chose Harvard Medical School several years later was to explore the current research on the medical benefits of meditation. Promising studies suggested that meditation could help control blood pressure,[9,10] chronic pain,[11-13] psoriasis,[14] and anxiety.[15] I also sought out other clinicians who would validate my own experiences and help me translate them into a medical culture. This proved less obvious and more difficult then I had hoped. With the exception of some aspects of psychiatric training and Balint groups,[16] I did not see much explicit attention to the self of the practitioner.

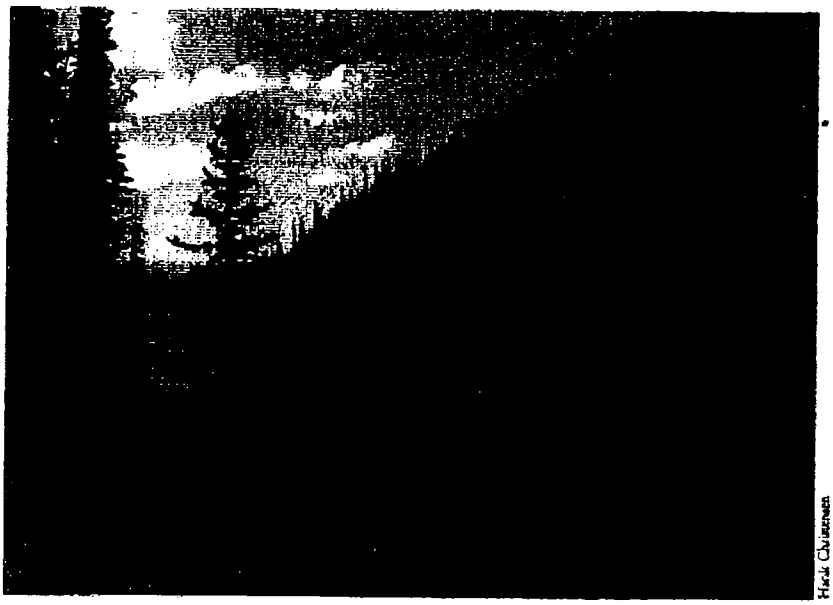
Imperceptibly, meditation has become a habit. Like brushing my teeth each morning, the day feels incomplete without it. It is a habit of practicing presence, just presence—no more, no less. It has been years since I have attended an intensive meditation retreat. For me now, it is a solitary, quiet endeavor. In fact, only some of my friends and a few of my colleagues know about my daily practice. Like many habits, it seems perfectly ordinary. I had always considered it part of my private life. I do have some trepidation about going public, though, in that I do not want to promote one method, especially one that may have religious connotations for some. Nor do I consider myself an expert or a teacher of meditation. There are many other quiet meditators in medicine—I am far from alone.

MINDFULNESS

Mindfulness means paying attention, on purpose, to one's own thoughts, feelings, and judgments[17]—"observing the observer, observing the observed."[18] Buddhist meditation is the practice of mindfulness and requires only the belief that knowing oneself can foster compassion.[19] There is no other requirement, including adherence to any particular cosmology; many people practice meditation and continue to observe Judaism, Christianity, or Islam.

The simplest mindfulness practice involves finding a place free from distractions. With eyes either closed or partially open (depending on the tradition) while in an upright sitting posture, the practitioner pays attention to thoughts and feelings as they arise without trying to change, judge, or categorize them. Some traditions use the breath to focus attention, others use imagery, and some use nothing at all. Buddhist teachers call this "just sitting."[17,19,20]

Rather than a practice of well-being, I prefer to call mindfulness a practice of "just being." That is, as soon as another purpose is assigned (feeling good, lowering blood pressure, and so on), it somehow limits the process. I have to practice just being because it does not come naturally, and my efforts are always imperfect. There are also difficult moments, when insights are neither pretty nor de-



Heidi Christensen

sired. At those moments, and others, a teacher and a community of others involved in similar activities can be very helpful to provide insight, support, and encouragement.

Meditation is visceral learning and feedback. The visceral lessons are transferable to clinical and teaching settings. My habit of pausing before I enter a patient's room is a momentary state of repose and stillness, usually invisible to others. I give myself the gift of being present with myself while trying to give my patients my attentive presence. I often experience moments of quiet in the midst of action. By allowing me to be more present and less distracted, I believe these moments contribute both to the patient's feelings of having been heard, as well as to my own feelings of satisfaction at the end of the day. These moments also contribute to creative thought and writing. In administrative meetings, mindful practice is more difficult for me to achieve. Perhaps it is because the purpose of such meetings is not always to foster healing, satisfaction, or presence. But I do believe that it is possible and especially necessary to cultivate mindfulness in such settings.

MUSIC

Musical practice has had a different influence. Because I trained first as a musician, then later as a physician, I was surprised in my otherwise excellent medical education by a striking lack of attention to the self of the practitioner. In contrast, in music study, which can be as theoretically and technically complex as any medical specialty, the self of the performer is an object of constant study and reflection. While the performer is always playing some subject, the music must move and speak to a listener. There is l room for error; even the inattentive mind catches wr notes. Music requires observation-in-action and the ab to hear the sound—in one's mind—before it is produ The performer's presence creates a relationship with listener. In that way, musical performance is a bit m like being with patients, and meditation is more like silences in between.

BEING WELL

There are many ways for health professionals to enha well-being, to reflect, and to be mindful. A recent stu indicates that mindfulness meditation training for med students improved their psychological and spiritual w being and also improved their capacity for empathy

Organizations that offer instruction in mindfulness, meditation, well being, and self-care

The Center for Mindfulness in Medicine
University of Massachusetts
Phone: (508)856-2656; www.umassed.edu\cfm

Offers programs for professionals, patients, and the lay public

The Omega Institute
Rhinebeck, NY
Phone: (845) 266-4444; www.eomega.org

Offers seminars, workshops, and intensive courses for health professionals and the lay public

The National Association for the Clinical Application of Behavioral Medicine
Mansfield Center, CT
Phone: (860) 456-1153; www.nicabm.com

Offers conferences several times per year that include lectures and workshops

The San Francisco Zen Center
San Francisco, CA
Phone: (415) 863-3136; www.sfzc.com

Provides opportunities for training in meditation and is engaged in community and healthcare projects

Insight Meditation Society
Barre, MA
Phone (978) 355-4378; www.dharma.org

Offers training and retreats in Vipassana Buddhist meditation

John Christensen, PhD
Portland, OR
Phone: (503) 413-3544; christe@ohsu.edu and
Penny Williamson, ScD
Baltimore, MD
Phone: (410) 235-0344

Offer workshops to enhance physicians' effectiveness and well-being

Meditation is not for everybody, however, nor is studying music. The Greeks advocated that music study be balanced with gymnastics. They felt that too much music softens the soul and too much wrestling hardens it. This seems like good advice, not only because of the medical benefits of exercise, but because it is useful to develop mindful practice in more than one sphere of life. There are many other means to become more present, reflective, and caring. These include keeping a journal, exercising, creating art, spending time in nature, and gardening.

What will it take for medicine to become a more reflective, mindful practice? In my view, more important than developing reflection groups in medical school and residency will be the collective work of individuals who are willing to let themselves be known. The commitment to develop and use self-knowledge may be as important in promoting self-caring and compassion as the insights gained. I am impressed by the number of physicians who do practice mindfully, but do so in isolation. Perhaps they feel that to reveal their inner lives would threaten their credibility as professionals. Mindfulness underlies all efforts to be with, to know, and to care. We have something to learn from musicians in that regard, for whom public demonstration and performance of a mindful activity is at the core of their profession.

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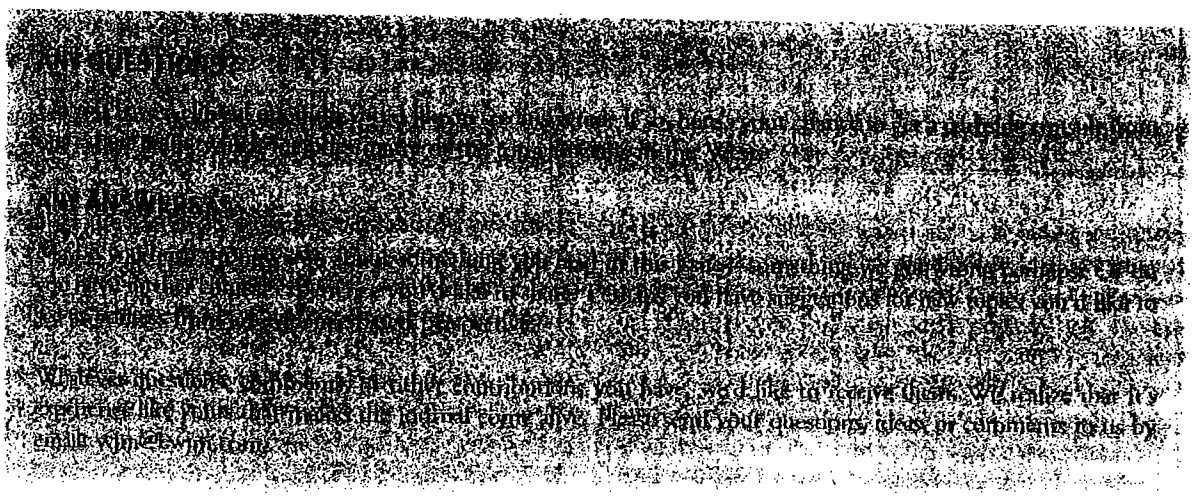

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ORIGINAL PAPER

ALTERNATIVE MEDICINE IN THE WORKPLACE

Richard A Lippin, MD

Richard A Lippin is corporate medical director of ARCO Chemical Company, Newtown Square, Pa, and founding president of the International Arts-Medicine Association.

Workplace settings are ripe for the application of alternative medical interventions for a variety of reasons. Included among them are a shared interest in prevention by both the occupational and alternative medicine communities, economic incentives by corporations as major purchasers of healthcare to reduce healthcare costs and improve employee productivity, and the willingness of corporations to be differentially creative in their approach to delivering and purchasing healthcare. This paper describes the US workforce in transition, provides an overview of occupational medicine including current programs and emerging issues, describes the current applications of alternative medicine interventions in the workplace, and argues for future expanded application of alternative medicine in workplace settings. (Alternative Therapies in Health and Medicine. 1996;2(1):47-51)

WHAT IS OCCUPATIONAL MEDICINE?

An inquiry into the application of alternative medicine in the workplace should begin with the recognition that this activity falls within the specialty of occupational medicine.[1] This branch of preventive medicine is concerned with:

- appraising, maintaining, restoring, and improving the health of workers through application of the principles of preventive medicine, emergency medical care, rehabilitation, and environmental medicine
- promoting a productive and fulfilling interaction of the worker with the work through the application of the principles of human behavior

This definition highlights the multifaceted nature of this growing specialty in medicine and provides a framework for successful and responsible application of alternative medicine in the workplace.

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SOCIOLOGY AND DEMOGRAPHICS

To characterize and plan for alternative medicine at the worksite, it is important to describe the basic sociology and demographics of the US workforce.

According to workforce expert and sociologist Ross Koppel, the civilian US workforce now totals more than 125 million, with adult men representing approximately 55.6% of this force and adult women, nearly 44.4%. White men no longer dominate the US workforce; the numbers of women and ethnic minorities continue to increase. The numbers of working older people, very young workers, and workers from other countries are also increasing.

Furthermore, the average number of hours worked by an individual per year is increasing. In her book *The Overworked American: The Unexpected Decline of Leisure*, Juliet Shore reported that with more women holding down "real jobs" and the continuing need for labor at home, the total hours worked by Americans of both genders has increased since 1969 by 163 hours per year to nearly 2000 hours (on average and not counting another 900 hours of work done at home).[2] In addition, workers are expected to change careers two to five times during a productive lifetime.

Goods-producing industries employ approximately 29.3% of working individuals; service-producing industries including government employ more than 25.7%; and 45% of workers are employed in offices.[3] The number of agricultural workers dropped from 7.1 million in 1960 to 3.1 million in 1985. The need for new personnel in environmental protection, energy development, and healthcare will increase openings for professional workers. Expansion of retail trade will lead to a greater number of salespeople; the hospitality, computer manufacturing, and robotics industries are growing as well.

The number of businesses with a small number of workers exceeds the number of firms with large labor forces. Large firms are more likely to use some form of on-site occupational health facility; small businesses are likely to use the services of outside healthcare consultants because of the lower costs of ad hoc external medical care.[1]

LEGISLATION AND REGULATION

To a large extent, occupational medicine programs are driven by federal and state regulations—pertaining to workplace

safety and health as well as hiring, personnel, and benefits practices—that have accelerated over the past 20 years. Among the more important laws relevant to alternative medicine are the Occupational Safety and Health Act (OSHA) of 1970 and the Americans with Disability Act (ADA) of 1992. Both laws directly address human health and capacity issues that influence the requirements of occupational health programs.

ON-SITE OCCUPATIONAL MEDICAL PROGRAMS

A fundamental reality of the workplace as a site for medical services is that it is convenient for on-site employees who live in an increasingly busy society. This phenomenon and fundamental health economics increase pressure on employers to provide more primary healthcare at the workplace. Because the American workforce is essentially healthy, the more logical goal of occupational medicine should be to prevent illness rather than to treat the ill and injured. The various kinds of health-related activities that may be undertaken as part of an occupational medicine program are outlined below.

- For regulatory and other reasons, occupational health professionals engage in a wide variety of examinations and evaluations.[7] Examples include: (1) preplacement surveillance exams targeting specific exposure, (2) return-to-work and fitness for duty, (3) pre-expatriation and repatriation, and (4) periodic health maintenance evaluations. Besides providing an opportunity for the physician to detect occupational and nonoccupational risks and diagnoses, and provide data for individual and group analysis, these examinations allow the physician to interact with individual employees to discuss lifestyle and behavioral change.
- Often, on-site occupational health programs also provide palliative care for limited, uncomplicated conditions. This care is geared primarily toward maintaining workplace productivity. For example, the practitioner may provide medication for mild upper respiratory infection, mild gastrointestinal upsets, menstrual cramps, headaches, and mild skin conditions.
- The primary responsibility of the occupational physician is the management of occupational illnesses and injuries that can be both complicated and prolonged.
- In corporate settings emphasis on fitness and wellness programs, including scientifically based exercise, recreation, and a wide array of health education and behavioral change seminars, is growing.
- Employee assistance programs, which began in the 1970s, have successfully addressed many mental health issues affecting workers but often have failed to address adequately the major issue of workplace stress.
- The workplace can be viewed as a logical, accessible location for delivering a wide range of primary and secondary preventive medical services including medical screening and immunizations.
- Many safety-sensitive industries (such as transportation, nuclear, and chemical) conduct drug and alcohol screening.
- Occupational physicians and other health professionals are in a unique position to advise employees on appropriate utilization of the external healthcare community and serve as ombudsmen and advisors in this regard.
- Occupational physicians may also participate in planning, providing, and assessing the quality of employee health benefits.

MAJOR AND EMERGING ISSUES IN OCCUPATIONAL MEDICINE

Because of the trend in the 1980s toward corporate restructuring, which led to corporate downsizing, workplace stress has increased. In addition, the cost crisis in healthcare is forcing companies to use the workplace to emphasize prevention and the importance of managing both nonoccupational and occupational illnesses and injuries in a cost-effective manner. The Circadian Group, based in Cambridge, Mass, has stated that in order to be competitive in the 21st century, US industry must move from a machine-centered technology to a human-centered technology that requires increasing reliability on human performance, with an emphasis on protection of human assets. These issues all affect planning for occupational medicine, including alternative practices, at the worksite.[7]

Some work-related issues that may prove amenable to alternative medical practices are described below; potential alternative medical approaches to these problems are presented in the following section.

In 1983 the National Institute of Occupational Safety and Health (NIOSH) listed 10 leading work-related diseases based on their frequency of occurrence and amenability to prevention (Table). Although viewed by some as highly controversial, these 10 remain on NIOSH's priority list, a list that has been borne out in part by recent so-called epidemics in occupational medicine, including occupational stress and cumulative trauma disorder.

Cumulative trauma disorder appears to be a disease of our times, representing a clash between human anatomy and labor-saving technologies that require less gross muscle work but more repetitive small muscle and hand work than in previous eras. It strikes carpenters, musicians, butchers, meat packers, auto workers, gardeners, construction workers, supermarket checkers, assembly line workers, writers using computer keyboards, and others who use their hands repetitively with the wrist bent.

Work-related diseases based on frequency of occurrence and amenability to prevention

- occupational lung disease
- major injuries including amputations and fractures
- occupational cancers
- disorders of reproduction
- cardiovascular disease
- noise-induced hearing loss
- neurotoxic disorders
- psychological disorders
- dermatologic conditions
- musculoskeletal injuries

By some estimates, the incidence of cumulative trauma disorder among US workers is 1 in 10.[7] The US Centers for Disease Control and Prevention has reported, however, that no accurate, reliable data exist on the frequency of work-related cumulative stress disorder for two reasons: (1) inadequate training of health professionals to recognize these conditions and (2) underreporting of recognized cases. The accuracy of surveillance could be improved by establishing standard definitions for work-related musculoskeletal injuries.

Job stress is another problem at an epidemic level in this country.[8] Stress clearly is the major cause of productivity decline in the US workplace, with three stress-related disorders—chronic pain, hypertension, and headache—accounting for 54% of all absences, or $15.7 billion of the $80 billion loss in wages every year. Although definitions of job stress vary and more objective measures must be developed, 30% of adults report high job stress nearly every day, and an even higher percentage, once or twice a week. In a 1991 study by Northwestern National Life Insurance it was reported that more than one third of the respondents were considering changing jobs because of job stress. In California the prevalence of claims for gradual mental stress more than doubled from 1980 to 1982, whereas claims for all other disabling injuries actually decreased by more than 10%. Furthermore, mental disorders are the most prevalent (21%) of disabling conditions among recipients of Social Security Administration funds for disability. When the New York Business Group on Health polled 201 personnel and medical directors of small, midsize, and large corporations, the results were that depression affected 24% of their employees on the average, and led to an average loss of 16 days of work annually.[9] Violence in the workplace, including homicide, is also a growing concern.

In a June 1991 letter[10] the author proposed a new research model for the common cold that implicates stress, suggesting that although the presence of a virus may be indisputable in each case, it does not necessarily play a causative role and that, anecdotally, a direct correlation has been found (by the author) between periods of intense stress and the onset of a cold. The situation is proposed to involve a parasympathetic breakthrough or payback phenomenon that others have misdiagnosed as being caused by a virus. The phenomenon produces symptoms typical of an overactive parasympathetic nervous system, including increased mucus, sweat, and tear production; generalized muscle aches; and nausea and diarrhea. Related to this hypothesis, in August 1991 Sheldon Cohen and colleagues at the University of Pittsburgh reported an association of psychological stress with increased incidence of the common cold.[11]

Other topical issues that are emerging in occupational medicine are air quality, multiple chemical sensitivity, environmental tobacco smoke exposure, shift work, vigilance and fatigue, and travel, especially international. Upper respiratory infections still account for a large percentage of lost work days, and back injuries make up 20% of occupational injuries in the United States, costing as much as $30 billion each year. Some sources predict that 80% of the working population will at some time during their careers experience significant low-back pain. Some 20% to 25% of all the back claims in industry account for 90% of the costs of such injuries.[12] The National Safety Council estimated that in 1986 approximately 10,800 deaths resulted from accidents in the workplace. In addition, 1.9 million people sustained work-related disabling injuries, and total work accident costs for 1984 were estimated at $32.4 billion.[1]

APPLICATION OF ALTERNATIVE MEDICINE INTERVENTIONS IN THE WORKPLACE

Alternative medicine is practiced infrequently in the US workplace, with some notable exceptions such as massage, acupuncture, and informal nutritional interventions. Procedures that promote alertness, relaxation techniques, and arts-medicine (a study of the relationships between human health and the arts) interventions are beginning to be used as well.

• Among the more successful alternative medicine interventions in the workplace is on-site massage therapy. Although precise statistics in the field are not yet available, Elliot Greene, past president of the American Massage Therapy Association, indicated in a 1995 letter (to the author) that more than 80 companies, many of which are Fortune 500 companies, are using massage therapy to counter such ills as musculoskeletal problems, stress, and poor ergonomic design of furniture. The association itself has grown from 1500 members in 1983 to 22,000 members in 1995, with accredited schools increasing from 12 to 60 during the same period.

Companies offering on-site massage include Apple Computer in California, Merrill Lynch and NBC in New York, the *Dallas Herald Tribune*, SmithKline Beecham and Conrail in Philadelphia, Ben and Jerry's Ice Cream in Waterbury, Vt, and Wampler Longacre Chicken Company in Virginia. The latter provides an around-the-clock massage therapist for more than 1000 workers in its large poultry plant in an effort to decrease the incidence of cumulative trauma disorder. A typical on-site massage takes about 15 minutes and costs much less than a full-body treatment, with charges based on the length of the session. The client remains fully clothed and sits on a stool or a specially designed chair. The finger pressure techniques used in this approach are adapted from traditional massage and Oriental styles of acupressure massage.

Similarly, the growing popularity of office massage appears to be linked to a dramatic increase in repetitive stress injuries related to intensive use of computers; the emphasis is on massage of the neck and shoulders.[13]

In an unpublished 1993 manuscript, Field and colleagues of the Touch Research Institute, based at the University of Miami School of Medicine, reported preliminary findings of a job stress study designed to assess the effects of massage therapy on job-related stress and anxiety and also productivity and job satisfaction. A 15-minute chair massage was provided twice weekly during lunch for 5 weeks. In preliminary results participants reported feeling less fatigued and being able to think more clearly. Electroencephalogram, alpha, beta, and theta waves were

altered in ways consistent with enhanced alertness. Math problems were completed in approximately half the time required without massage, with approximately 50% fewer errors by the end of the intervention; also, anxiety levels were lower at the end of a 1-month period.

• Acupuncture has been used in some smoking cessation interventions. According to corporate medical director Peter Devine, MD, of Bell Telephone of Pennsylvania, an auricular acupuncture "clip" technique has been successful in some cases.

• Regarding nutritional interventions in the workplace, current practices are likely to be informal and voluntary, with workers dosing themselves with vitamins or other nutrients that they believe are likely to improve their health. However, if clearer proof becomes available that such practices do promote health, company cafeterias can be readily modified to take advantage of an increased emphasis on nutrition and health and the link between food, stress, and performance.[11] Because upper respiratory infections occur frequently in the workplace, vitamin therapy, as first promoted by Linus Pauling in 1970 and recently confirmed by researchers from the University of Helsinki and the Linus Pauling Institute of Science and Medicine, might be of particular interest as a potential method of reducing the severity of colds.[12]

In addition, interest is increasing in the concept of chemoprevention, or use of (antioxidant) vitamins (vitamins C and E, for example), as a method of reducing one's risk for cancer.[13-17] Although only a decade or two ago efforts at chemoprevention were not regarded seriously, this approach is now being studied in many major cancer centers around the world.[18] This development has implications for prevention of both occupationally and nonoccupationally induced cancer. The incidence of occupational cancer ranges from 0% to 5% of all cancers[19]; however, the public has the perception that industrial processes contribute to and possibly cause cancer in a significant number of cases. It may be helpful for industries to engage in chemoprevention techniques at the workplace—supplying antioxidant regimens to their employees to decrease the risk of contracting cancer, regardless of the cause.

•Employee alertness is beginning to be addressed by some alternative medicine techniques. Dr Martin Moore-Ede, president of Circadian Technologies, Inc, and associate professor of physiology at Harvard Medical School, has stressed the importance of alertness, indicating that modern managers must learn how to select and train teams of employees, schedule work and rest time, and organize work paths to ensure that safety, productivity, and quality are maintained 24 hours a day. Because of increased international travel, Moore-Ede also cites the need to learn how to combat jet lag by using scientific breakthroughs that have enabled us to control the biological clock. For example, the discovery of the role of suprachiasmatic nuclei in the hypothalamus in generating rhythms of sleep and wakefulness, and the identification of the phase-response mechanisms by which bright light (approximately 2500 lux) resets this biological clock, have laid the groundwork for new techniques for precise control of the timing of sleeping and waking, alertness, and performance.

In *The Twenty-Four Hour Society*,[5] a book that addresses the future of work, Moore-Ede describes technological breakthroughs for increasing alertness including strong doses of bright light, redesign of control room environments, and visors that supply strategic shots of light while the wearer is aloft. Because the alertness or drowsiness of employees can now be precisely measured using brain wave (electroencephalogram) and eye movement (electro-oculogram) analysis, precise design specifications for ensuring employee alertness can be determined. Jobs and workplaces can be designed to promote alertness by building in such stimuli as muscular activity, light, temperature, sound, and aroma. Interestingly, third shift workers at the Nestle Food decaffeination plant in Illinois do not need to drink coffee to stay awake, perhaps because an aroma promotes alertness either by psychological association or by direct inhalation of caffeine.[5]

• Among the most widely accepted methodologies for addressing workplace stress are various relaxation techniques. Herbert Benson, MD, a mind-body pioneer at Harvard Medical School, defined the relaxation response in 1974.[20] The relaxation response is defined as a series of coordinated physiological changes elicited when a person engages in a repetitive mental or physical action and passively ignores distracting thoughts. The alterations include decreases in oxygen consumption, heart rate, respiratory rate, and blood pressure, and increases in the intensity of alpha, theta, and delta brain waves. These are the opposite of changes that occur during the stress response.

The Center for Corporate Health and the Center for Training in Mind/Body Medicine have become integral parts of the Mind/Body Medical Institute that Benson directs. Other prominent leaders in the work-stress management area are Robert Elliot of the Institute of Stress Medicine International in Littleton, Colo; Richard Rahe at the Nevada Stress Center, University of Nevada School of Medicine, Reno, Nev; and Myrin and Joan Borysenko of the Mind/Body Health Sciences, Boulder, Colo. It is also notable that Mutual of Omaha Insurance Company recently decided to provide coverage for a program designed by Dean Ornish, MD, a cardiologist who integrates nutritional principles and meditation into his regimen of cardiovascular disease prevention.[21]

• In another approach to stress reduction, the new field of arts medicine involves the application of the arts as a therapeutic or preventive intervention in the form of one or more types of art therapy.[22] Also of interest to employers and employees is the potential for the arts to serve as a creativity enhancer. ARCO Chemical Company, an international corporation headquartered in Newtown Square, Pa, under the author's medical direction, sponsored art and creativity workshops led by a professional artist who taught techniques for drawing faces in a self-esteem–building exercise. It is now generally recognized that aesthetic stimuli including light, color, sound, rhythm, and even words may have a salutary impact on human health.[23,24] Furthermore, ARCO Chemical Company has introduced, as part of the health education component of its fitness and wellness

program, a session called "Lunch and Laugh," which exposes employees to humorous stimuli and elicits laughter to reduce stress during the lunch hour. This program is based on the hypothesis—advanced by Norman Cousins[24] and the physiological research of William Fry[25] of Stanford University—that laughing has a salutary effect that can be measured.

Similarly, in 1985 the author proposed using stress-releasing techniques at the worksite to reduce both illnesses and accidents.[27] Techniques besides laughter that are likely to reduce stress include crying, writing, and hitting or kicking exercises.[28]

FUTURE APPLICATIONS OF ALTERNATIVE MEDICINE IN THE WORKPLACE

Future applications of alternative medicine in the workplace are limited only by the creativity of healthcare providers and the courage of the business leaders who control the purse strings of health coverage. As we enter a postindustrial era in which human-centered technology is stressed, health and human performance will be increasingly valued in corporations whose leaders wish them to remain competitive.

Emphasis at the workplace will continue to be on prevention of health problems and on alternative medicine practices whose products and interventions achieve this goal. Some of these approaches have been discussed in this paper. Many other legitimate alternative medical interventions are likely as well to have potential application in the worksite.

Alternative medical interventions are relevant to off-site as well as on-site healthcare services. Because corporations represent a major purchaser of off-site healthcare services, creative corporate medical directors can assist with benefits planning to ensure appropriate consideration of alternative medical third-party coverage. Hence, corporate medical directors should make an effort to understand alternative medical practices that relate to treatment as well as those that are useful for worksite prevention practices. Off-site healthcare services may include those that are targeted to pain management and short-term and long-term occupational and nonoccupational disability case management.

The burgeoning area of human performance issues for employees from executives to hourly workers also provides opportunities for alternative medical interventions. These issues, which include alertness, stamina, and certain cognitive or physical skills, represent a recognition that the prevention and treatment of illness are not medicine's only goals. In healthy working populations, the enhancement of human performance may be addressed. A positive aspect of this trend is that capacity enhancement emphasizes that which is healthy within an individual, rather than stressing pathology, as Western medicine so often—and perhaps necessarily—does. This approach might be described as the rebirth of medical optimism.

Occupational medicine professionals must exercise caution in the area of employee performance and not be tempted to prioritize performance over health, which might place the employer's interests ahead of the employee's. Properly integrated, performance and health should support one another.

SUMMARY

Applications of alternative medicine at the worksite are already being used in a limited way, especially massage therapy and relaxation techniques. Corporations, as both major providers and purchasers of healthcare, can be an especially potent force in advancing safe and effective alternative medicine at the worksite. Many social factors argue strongly for advancing alternative medicine at the worksite. These include the centrality of work in our lives, the rapidly changing face of America's workforce and the nature of work, and the desire for the United States to remain competitive in a world economy.

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Discussion Group Questions

Divider Title: _____

CAM in Self-Care and Wellness

March 27, 2001

Workgroup #1 - CAM in Self-Care and Wellness: Nutrition

Facilitator: Joe Pizzzorno

This workgroup will:

1) Identify 3-5 issues related to CAM, wellness, and nutrition based on the testimony provided.

2) Develop 2 or more recommendations for consideration by the full Commission to address the issues identified.

Workgroup #2 - CAM in Self-Care and Wellness: Special Populations

Facilitator: David Bresler

This workgroup will:

1) Identify 3-5 issues related to CAM and special populations based on the testimony provided.

2) Develop 2 or more recommendations for consideration by the full Commission to address the issues identified.

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IV. PUBLIC COMMENT

Divider Title: _____

Public Comment Session

1. **Michael Zeng, MD (China), DOM** , President, International Institute of Chinese Medicine
2. **David Edgar Molony, Dipl Ac & CH, Lisc Ac,** American Association of Oriental Medicine
3. **Marcellus Andre Walker, M.D.**, africanamericanhealth.com
4. **Diana L. Chambers**, Friends of Health
5. **Robert D. Miller**, The First Church of Christ, Scientist
6. **Kathleen Mary Quain, C.S.W.**, Foundation For Health & The Environment
7. **Donald M. Epstein, D.C.**, President, Association For Network Care
8. **Paula Kim**, Chairman of the Board and CEO, Pancreatic Cancer Action Network (PanCAN)
9. **Jennifer Roe, BA**: American Association of Naturopathic Physicians
10. **Scott Lamp, C.M.T.**, American Massage Therapy Association
11. **George A. Kurtz**, President, Feldenkrais Guild of North America
12. **John Philip Adams, D.C., P.C.**
13. **Bruce Nordstrom**, DC:American Chiropractic Association
14. **John D. Melnychuk**, CCH, LCCH: California Health Freedom Coalition

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Divider Title: Integrative Approaches

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Zeng

Divider Title: _____

Michael Zeng, MD (China), DOM
President, International Institute of Chinese Medicine

NOTES:

1. The place of TC/O Medicine in CAM: Long historical process of devpnt: 4000+yrs vast body of related literature; theory and practice; 2. Should be accorded a status similar to allopathic medicine; insurance coverage;fed reimb; 3. Appeal for consistency in standards of traing/cert; Many states allow MD's or DC's to practice acupuncture with little or no training. Accredited schools or AOM provide between 2400-3200 hours of training. Should be addressed re: effective treatment and patient safety.

Dr. Michael Zeng, MD (China), D.O.M.
President, International Institute of Chinese Medicine
P.O. Box 29988
Santa Fe, NM 87592-9988
(505) 473-5233

Oriental Medicine, based upon Traditional Chinese Medicine, is an approach to healthcare with over 4000 years of development and refinement. It originated in China and spread to Korea, Japan, and other regional countries, and then to the rest of the world. From its pioneers' careful observation of the human struggle against disease, Oriental Medicine has developed its systematic character, theory, and clinical skills. These are documented in a vast body of literature covering its theory and practice.

Oriental Medicine's fundamental approach is based upon the principles of yin and yang, five elements, and channel and collateral theory. It has a distinctive perspective on both pathology and the etiology of disease, and focuses strongly upon the differentiation of syndromes to distinguish and treat illness.

An important feature of Oriental Medicine is its recognition of the interconnection between the physical, psychological and spiritual aspects of the patient. It stresses the integration of all these in order to treat the whole person, rather than the disease, with a focus upon prevention as opposed to cure.

Western medicine is built upon the foundation of biomedical science. Its characteristic approach, *bian bin*, is concerned to identify specific *diseases* and to treat them, typically through the administration of drugs or surgery, according its established scientific canons. It is, in this sense, a very objective approach, and one whose applications may be judged upon a corresponding objective basis.

Oriental medicine does not share this model, or the sense of scientific certainty that goes with it. Instead, it emphasizes *bian zheng*, and requires practitioners to draw upon their experience to distinguish the appropriate *syndrome.* This requires skill in arriving at a synthesis of what can be exceedingly complex indicators of the syndrome affecting the patient.

These basic differences will present challenges for researchers trained according to the Western model. As we work together to integrate Oriental medicine into our national health care system, many have called for more research into its effectiveness. It is our hope that increased cooperation among researchers from both Oriental and Western medical backgrounds will allow us to make progress in this much-needed work.

Today, Americans are turning to Oriental Medicine in ever-increasing numbers. They view it as providing simple, economical and effective treatment with no major side-effects. Surely, both approaches have an important role to play. It is vital, therefore, for the optimal delivery of services, that reimbursement for acupuncture and Oriental Medicine

treatments be addressed by both private and government insurance programs. We look to the Commission for assistance in achieving this important goal.

Like many of my colleagues, I am very concerned that many states now allow medical doctors to practice acupuncture with a bare minimum of related training, or even with no training at all. This removes acupuncture from its intellectual roots, with the potential to damage our profession, and is contrary to the best interests of the public at large.

I suggest that we work for the establishment of national standards of training that will apply equally to all. While medical doctors who wish to practice acupuncture should certainly be allowed to waive elements of the required Oriental Medicine curriculum, they should not be excused from meeting the educational standards established for all other practitioners. These are minimum requirements that should apply to all, in the interests of fairness and to ensure the safe and effective delivery of acupuncture and related treatments to health care consumers. We should have no privileged class of practitioners who are exempt from the standards established for all others.

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Divider Title: Molony

White House Commission on Complementary and Alternative Medicine Policy
CAM Self-Care and Wellness
November 27, 2001

Good afternoon Commissioners;

My name is David Molony. I am an Oriental Medicine professional and the Executive Director of the American Association of Oriental Medicine.

The Oriental Medicine profession is the most comprehensive, far reaching, credible, and accepted CAM field of medicine in the United States. We have, in place, national education, accreditation and certification examination standards in acupuncture, herbal medicine and bodywork. An intrinsic part of our education involves patient education on wellness and self awareness, which we feel expands to family members and friends.

While public awareness on self care can be part of an ad campaign, the most headway can be found in a positive personal experience with a practitioner or a close friend or relative who has had such an experience. The expansion of Oriental Medicine in the United States has brought just such profound experience to the lives of many, and this has provided for the logarithmic expansion of our field with such rapidity that it has continued to evolve into a field of medicine in its own right.

People using internal and external martial arts are understanding that balance is more than physiological homeostasis. They know that many times simplification and a strictly personal understanding at the basic levels of human comprehension of concepts such as Yin and Yang and the concept of Qi with its movement throughout life provide a sense of health that can enhance ones ability to cope with any infirmity. This is not religion, but it works with any religion that is open enough to use it to enhance well being.

Education in Oriental Medicine colleges always involves some form of development and manipulation of Qi, to provide for better treatment and also for self regeneration after treating. While this is not always consciously imparted, during an acupuncture treatment for instance, the shared experience provides a venue for observation of that movement and the acceptance of the qualities of Qi that surround us. This is a very important aspect of an acupuncturists interaction with a patient.

Other aspects of Oriental Medicine that work well within a self care model are over the counter herbal preparations with a simple understanding similar to that used for OTC remedies here in the United States. It is not hard, for instance, to differentiate between 3 or 4 cold remedies, which will increase the likelihood of a rapid recovery tenfold. Uneducated countryside folks in China do this on an everyday basis, with good results. I expect that we will see this sort of thing evolve into the norm over the next few decades, assuming that the public health is considered an over riding factor compared to fiduciary interests or dogma. Diet is also an important aspect, and we have certainly evolved away from the simple understanding of how we interact with nature by how we eat. Simple awareness of the hot and cold natures of foods relative to our state of health can provide a wealth of wellness information that can be used on a daily basis to achieve a longer, more productive life and a less drawn out death.

The profession of Oriental Medicine looks forward to working with Conventional health care in the United States to enhance the well-being of the public through use of the oldest and most renowned longevity and wellness practices in the world.

American Association of Oriental Medicine
433 Front Street
Catasauqua, PA 18032
888-500-7999
Fax- 610-264-2768
www.aaom.org

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Walker

Divider Title: _____

Marcellus Andre Walker, MD
africanamericanhealth.com

Diana L. Chambers
Friends of Health

NOTES:
I will focus on wellness provision for underserved populations.

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Divider Title: Melnychuk

The White House Commission on Complementary and Alternative Medicine

Public Testimony offered by John D. Melnychuk R.S. Hom (N.A.) © © H.
President, California Health Freedom Coalition

27 March 2001

I am John Melnychuk, President of the California Health Freedom Coalition, a not for profit consumer group which is working for health care reform in California. We represent consumers in California who would like easier access to all types of high quality forms of healing practices.

We are working to make a change in the culture of medicine and healing in California.

Thank you, Commission members for your hard work, and for welcoming me here today. It's nice to be here where we can all count on the lights remaining on.

We are tired now, after receiving testimony from many witnesses and considering so many issues, so I'll try to be brief.

I grew up in Canada, trained as a classical homeopath in England, and have worked and lived in both of these countries and also, of course the U.S. I have been admitted to the U.S. on the basis of "extraordinary ability" in homeopathy. I have traveled extensively, taught and treated using homeopathy as Vice President of Homeopaths Without Borders, and as Director of Homeopathic Programs for Airline Ambassadors International, an United Nations NGO. Both are humanitarian aid organizations which offer treatment and education to under served communities, so I feel I am in a good position to provide some observations from inside and from outside about health care in America.

It is clear that there is now an enormous interest in America about finding better ways of maintaining health and recovering it when it is diminished.

Problems in America

Three of the greatest problems facing American health care consumers are:

a) limited access to high quality health care services of any sort

b) the expense of the limited choices available,

c) the lack of success of a "one size fits all" kind of medicine

Lack of Freedom in a Health Monoculture

America, unfortunately, is not so free as some other countries as regards access to health care. There is brilliant technological medicine here but the culture here is overwhelmingly a "monoculture" of scientific allopathic out-of-reach-for-millions expensive medicine. The ideal of a "monoculture" or homogeneity of medicine in America, I wonder, does it have it's roots in the American ideal of the "melting pot" where immigrants abandoned their cultural ancestry as a way of becoming truly American?

Who should be satisfied Consumers, or the Government Agencies?

The health care culture here in America is very much oriented to remediation. There is a tremendous reliance on the thought that someone else, usually doctors, insurance companies, or the government, via the Food and Drug Administration, or the Federal Trade Commission or other agency will and ought to care for any individual's health. There is a suspicion, among some of these agencies that consumers are fools, and non-licensed "unscientific" healers are fundamentally defrauding the public.

Art, Science and, Common sense in Medicine

It struck me that yesterday, when we heard the testimony from the FTC and the FDA that they have developed their regulations with a great deal of logic, but very little common sense. After yesterday's discussion, I am more doubtful of their effectiveness in looking after my interests. Science, of course is important but, after all, health care disciplines as a group are known as the "healing arts."

It was disappointing to hear the sentiment expressed that, "it doesn't really matter what we recommend, what it all really comes down to is what the insurance companies will pay for." This commentary I heard at your meetings in early December 2000. I don't believe this is the truth, and I am heartened to see that the Commission has developed more confidence in it's ability to effect change.

Where then, should the burden of responsibility lie for any American citizen's health? We at CHFC think it should lie with the citizen and their health care providers and not with regulatory or enforcement agencies.

You have heard from many, many people who have testified about the benefits of so called complementary and alternative practices. All of these people are very courageous as they fight for their health and lives by pursuing what is here thought of be unconventional approaches. It is important to know that what are strange or alternative practices here are common in other places because health consumers there have found them to be effective. All of these consumers have voted with their dollars. They are betting their health and sometimes their lives as they try to find something that will work for them as individuals. They are proof that there is great interest in self care as they do not merely accept what the system has to offer.

Access

One of the most serious problems facing Americans as they look for better solutions to their health care is that of access. It is not only money here that limits people from accessing health care that works for them. It is also the illegality of alternatives in many jurisdictions. Standard of care and prevailing practice rules prevent many licensed providers from offering something beyond conventional treatments which can't always help everyone. Laws which define medicine as "any healing and diagnosis" also limit access to people to complementary and alternative healing practices by making it illegal for talented non-medically licensed healers to provide services. The hostile working climate for non-medical healers prevents them from working, and this limits access for all. Consumers then, are prevented from seeing these people and assuming responsibility for their own health.

Most of these healing practices in fact demand the participation and the collaboration of the consumer.

We would like to recognize that people in California are making self care a priority as they choose something outside of what is given to them by their insurance companies and a system that often does not meet their needs. The first thing we would like to do is to make it legal for people to provide care. The consumers are already coming and using these healers' services – if there weren't a lot of people doing this we wouldn't be here discussing it.

We at the CHFC don't think is a good idea is to mandate standards and licensing boards for every single discipline; it is boggling to think of such a

thing. Many of the problems in health care in America have come precisely because of the design of the current health care system, and the overwhelming legal advantage that allopathic medicine holds. If allopathic medicine is the most scientific of all medicines, could mandatory governmentally regulated standards be possible to devise? If it be could done, and would it benefit the public? I don't think so – part of why we are here in these meetings is to try to come up with better ways of helping the public become more healthy. More licensing boards will not help Americans become more healthy.

Nuance and Sensitivity

In closing, I would encourage the Commission to examine American health care from a cultural perspective, not just from that of American medical science. Pluralism even in health care is good. I am reassured that the you as Commissioners are becoming multilingual and multicultural in this process of studying and analyzing what is happening in the health care landscape in America. It is necessary to have a multicultural sensitivity to appreciate the nuance of many of the healing arts you have been made aware of since the inception of the Commission. Please design your recommendations with a sensitivity to other healing practices, and with a spirit toward encouraging the public to access what it is they would like to access. After all, the bottom line is that the consumer should be satisfied, not the scientists, and not just the governmental bodies overseeing health care in America.

14

John D. Melnychuk, RSHom(NA), CCH

655 Homer Avenue
Palo Alto, CA 94301
(650) 323-5656
email: jmelnychuk@igc.org

PROFESSIONAL EXPERIENCE

Homeopathic Consultant, in private practice in Palo Alto, California 1994 - present. In New York, New York, 1996-1998

Lecturer, Pacific Academy of Homeopathy, San Francisco, California. 1999 - present.

Director, Homeopathic Programs, Airline Ambassadors International, San Francisco, California. 1999 - present.

Airline Ambassadors International is a United Nations accredited Non-Governmental Organization (NGO) that provides humanitarian aid in developing communities domestically and internationally. I provide homeopathic education and training to health care workers and volunteer members. I also supervise clinical training of homeopaths, student homeopaths, and other health care providers on overseas aid projects. In December 1998 I made a pilot trip to Bogota, Colombia and volunteered at the orphanage Hogares Luz y Vida. In February and August 1999 I volunteered at orphanages at Maxfield House and Marigold House in Kingston, Jamaica. In May 1999, I made assessments of refugee camps in Macedonia during the war in Kosovo.

Speaker
North American Society of Homeopaths Second Annual Case Conference, August 1999.
North American Society of Homeopaths First Annual Case Conference, April 1998.

Proving Extractor
A proving is an experimental trial of a new homeopathic medicine.
Performed initial analysis and editing of raw data for provings of:
Helodrilus, Oakland, California, 1997.
Haliaeetus Leucocephalus, Headlands, California, 1996.

Editorial Advisor of a new translation of the classic text, *Organon of the Medical Art*, by Samuel Hahnemann, M.D., edited and annotated by Wenda Brewster O'Reilly, Ph.D., 1993 - 1996. This text is the original work by Samuel Hahnemann that provides the philosophical foundation for Homeopathy.

Lecturer, Homeopathic Study Group for Parents, Palo Alto, California. 1994-1995.

Clinical Supervisor, London College of Classical Homeopathy, London, England. Taught undergraduate students in a clinical setting. 1993.

PROFESSIONAL EXPERIENCE (continued)

Research Supervisor, Dynamis College, London, England.
Coordinated data collection and initial analysis for a research study on a newly-developed homeopathic medicine. Neon. 1992 - 1993.

Editor, Miccant Ltd., Northampton, England. Upgraded and tested CARA's homeopathic repertory program. This computer program is the one most widely used by British homeopathic professionals and students. 1992 - 1993.

PROFESSIONAL SOCIETIES

North American Society of Homeopaths, Seattle, Washington.
Professional Member, 1994 - present.

Chair, Out-Reach Programs Committee, 1998-99 These programs provide low or no-cost homeopathic education and treatment in international and local communities.

Member, Ethics Committee, 1993 - 1994.

Council for Homeopathic Certification, San Francisco, California.
Professional member. 1994 - present.

California State Homeopathic Medical Society
Active member, 1998 - present.

BOARD POSITIONS

Vice President, Homeopaths Without Borders, and Liaison to the North American Society of Homeopaths.

Homeopaths Without Borders is a nonprofit organization that provides homeopathic care and educational programs in developing communities domestically and internationally. As a representative of this organization, I have traveled internationally to provide homeopathic training to health care providers. Part of my work has been to search for a suitable site overseas for a permanent clinic. This clinic will provide care to those in need and clinical training for health care providers.

Director, Building Project Committee, Homoeopathic Research and Charities, Mumbai, India.

HRC is a not-for-profit agency based in Mumbai, India. The founders of HRC are Indian leaders in the international homeopathic community and leading Indian citizens. HRC's main interests are homeopathic education, research, and treatment. The Building Project Committee is responsible for conceiving, designing and building a campus for an international teaching and research center in Lonavala, Maharastra, India

President, California Health Freedom Coalition, Palo Alto, CA. CHFC is working toward improving health freedom of California consumers.

PUBLICATIONS

"A Case of Germanium," in *The American Homeopath*, Volume 6, 2000.
This article chronicles the remarkable improvement of an individual after a single dose of a newly proved and rarely used remedy.

Book Review: "Prozac Free," by Judith Reichenberg-Ullman, N.D. MSW, and Robert Ullman, N.D., Picnic Point Press, Edmonds, WA. 1999. This review appeared in *The American Homeopath*, Volume 5, 1999.

"An Interview with Misha Norland, F.S. Hom." in *The American Homeopath*, Volume 4, 1998. This comprehensive interview is with one of Britain's most experienced and respected professors and practitioners of homeopathy.

Book Review: "The Patient's Guide To Homeopathic Medicine," by Judith Reichenberg-Ullman, N.D., MSW, and Robert Ullman, N.D. Picnic Point Press, Edmonds, WA. 1996. This review appeared in *The American Homeopath*, Volume 2, 1996.

Book Review: "The Dynamics and Methodologies of Provings," by Jeremy Sherr, Dynamis Books, Malvern, England, 1995. This review appeared in *The American Homeopath*, Volume 1, 1995.

Clinical Trial Review: "Is Evidence for Homeopathy Reproducible?" by David Reilly, M.D., The Lancet, December 1994. This article describes a trial of homeopathically prepared medicines at the Glasgow Royal Homeopathic Hospital. The review appeared in *The American Homeopath*, Volume 1, 1995.

EDUCATION and CERTIFICATIONS

Licentiateship with honours, 1993.
London College of Classical Homeopathy, London, England.
This four-year professional program in homeopathic medicine includes one year of teacher training.

Practitioner of Classical Homeopathy (PCH) degree, 1993.
Dynamis School for Advanced Homeopathic Studies, London, England.
This is a two-year post-graduate professional training program.

RSHom(NA) certification, 1994.
Registered Society of Homeopaths (North America).
This is currently the most stringent certification available for homeopaths in North America. There are currently only 80 registered members who have achieved this level of training and expertise in the United States and Canada.

CCH certification, 1994.
Certified Classical Homeopath.
This certification is also available for homeopaths in North America. There are currently only 200 homeopaths who have achieved this certification level.

EDUCATION and CERTIFICATIONS

Master Clinician Certification, 1998.
Luminos Homeopathic Courses, Ltd., San Francisco, U.S.A..This is two year post-graduate professional training program offered by Louis Klein, RSHom (NA). Louis Klein is one of North America's leading homeopaths.

Seminars/Workshops/Conferences

Attendance of numerous seminars and conferences in Canada, England, Scotland, and the United States, studying with a great number of internationally known homeopathic scholars including: Jeremy Sherr, Dr. Rajan Sankaran, Dr. Jayesh Shah, DR. Sudhir Baldota, Dr. Divya Chhabra, Dr. Sunil Anand, Dr. Sujit Chatterjee, George Vithoulkas, Sheilagh Creasy, Vega Rosenberg, Guy Kokelenberg, Roger Morrison, M.D., Murray Feldman, Laurie Dack, David Mundy, Peter Chappell, Louis Klein, Roberto Bianchini, Anna Schadde, Alize Timmerman, Dr. Nandita Shah, Dr. Farouk Master, Dr. Prakash Vakil, Dr. Sujit Chatterjee, Stephen King, Sheryl Kipnis, Nancy Herrick, Paul Herscu, N.D., Massimo Mangialavori, Jan Scholten, Robert Bannan, Rebecca Preston, Simon Taffler, Edward Chapman, Wenda O'Reilly, PhD, and many others.

Nurse Healers—
Professional Associates International
The Official Organization of Therapeutic Touch
www.therapeutic-touch.org

Oral Presentation to the White House Commission on CAM March 26-27, 2001

My name is Janet Ziegler, and as immediate past Coordinator of the Nurse Healers-Professional Associates International (NH-PAI) I am speaking on their behalf this afternoon. We would like to express our appreciation for allowing us this opportunity to participate personally in these very important and timely commission hearings on CAM policy.

NH-PAI was formed by Dr. Dolores Krieger in 1977 as a forum for nurses concerned with the healing aspects of the nursing interaction, and specifically to address the issues of the newly developed process of Therapeutic Touch (TT) which she co developed with Dora Kunz in the early 1970's. NH-PAI is an international organization. Although the majority of our members are nurses, we are also represented by members in many areas of health care, pastoral care as well as lay people. It was learned early on that everyone has a natural potential to develop the skills of Therapeutic Touch.

From the outset Therapeutic Touch has been studied using the scientific method. While the early research was not flawless, methodologies continue to improve and there has been a consistent output over the past 30 years, making TT one of the most researched based of the CAM modalities.

The Nurse Healers-Professional Associates International is the official organization of Therapeutic Touch and sets the standards for TT practice and education and promotes TT research.

I would like to address the issue of "energy modalities" being considered as a unit.

For the purposes of education, certification and accountability, modalities such as Therapeutic Touch, Reike, Pranic Healing, Healing Touch and others can NOT be treated as if they are similar. While on the surface they may appear to look alike:

1) the outer procedure and the inner process of each are considerably different.
2) The conceptual and theoretical basis and the basic assumptions upon which each modality is based are vastly dissimilar.
3) The professional education, credentialling requirements and research base for each are not remotely related.

These modalities are no more similar than osteopathy, chiropractic, massage and physical therapy are to each other. We hold each of these to specific standards, as we should all CAM modalities that seek credibility.

It is essential that each CAM modality that is practiced in a medical facility have its own appropriate research base, credentialling process, and specific policy/procedure for practice in a medical institution.

Because of the diversity in "energy modalities," to assure accurate utilization of the intervention, the official standard-setting organization for each modality should be responsible for teaching and educational requirements, and performance standards and practice guidelines.

To clump "energy modalities" together does a tremendous disservice to the general public, and to the medical professionals who may not be able to discern the significant differences among them. As with any healthcare practice, each energy intervention should be appropriately researched. We must guard against one "energy modality" claiming the research of another as its own. This violates the integrity and accountability that must be the standard for all CAM modalities.

Every intervention utilized in a medical facility must stand on its own operating under rigorous outcome-based research trials so the public can be assured of a full range of safe, effective CAM practices.

The NH-PAI fully concurs with the American Holistic Nurses Association position that "A nurse practicing as a therapist of a specific conventional or CAM therapy, must have the education, skills, and credentials ascribed for that therapy." Further, ANYONE practicing any CAM therapy must have the standardized education and credentials ascribed for that therapy.

I would like to thank you for this opportunity to speak to the Commission on behalf of Nurse Healers-Professional Associates International, the official organization for Therapeutic Touch.

Respectfully,
Janet Ziegler, MN, RN
Immediate Past Coordinator NH-PAI

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The Official Organization of Therapeutic Touch
www.therapeutic-touch.org

RESPONSE TO WHITE HOUSE COMMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

February 13, 2001

Dr. Joseph M. Kaczmarczyk (e-mail: KaczmaJo@mail.nih.gov, fax:
301.480.1691, phone: 301.435.6197 or 7592) and
Stephen C. Groft, Pharm. D.
Executive Director
Response to White House Commission on Complementary and Alternative Medicine Policy

Dear Dr. Kaczmarczyk and White House Commission Members;

Thank you for including Nurse Healers-Professional Associates International, the official organization of Therapeutic Touch, to participate in this worthwhile endeavor. For those members off the commission that are not familiar with Therapeutic Touch (TT) I will give a very brief history. Therapeutic Touch was developed in the early 1970's by Dr Dolores Krieger, then a professor of nursing at New York University, and Dora Van Gelder Kunz, a natural healer. Nurse Healers-Professional Associates International (NH-PAI) was formed in 1976 by the Dr Krieger and a group of professionals who felt there was a need to have an organized body to share information and to develop standards of practice and policy and procedure for this well researched and effective healing therapy. Dr Dolores Krieger, presently Professor Emerita, taught the first class in any college or University on a complementary therapy at New York University back in the late 1970's. This class was on Therapeutic Touch and is still being taught there today. In addition, TT is taught in numerous colleges and universities throughout the United States and in over 80 countries throughout the world. TT has the strongest research base of any other CAM therapy, including multiple doctoral and master thesis predominately in nursing. Therapeutic Touch is a nursing diagnosis according to the North American Nursing Diagnosis Association (NANDA.) Although primarily nurses practice TT, Dr Krieger and Dora Kunz realized that healing is a natural potential and other healthcare professionals as well as lay people can learn and use TT to help others.

I will address the interesting and in some cases challenging questions that were developed to guide the Commission's deliberations.

1. Are there national educational standards for Therapeutic Touch undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to CAM other than Therapeutic Touch?

Yes, there are national educational standards for Therapeutic Touch education which are set by Nurse Healers-Professional Associates International, the official organization for Therapeutic Touch. There are courses taught at the undergraduate, post graduate and continuing education level

While NH-PAI does not set standards for other CAM therapies, it supports and includes other CAM therapies in its conferences. Although many of our practitioners practice other CAM therapies and have taken classes from a person qualified to teach such therapy, they do not teach other CAM therapies in a TT class. Students in a TT class often ask questions while they are trying to compare TT with other modalities. TT teachers need to be familiar with a variety CAM therapy, but it is unrealistic for anyone to be current with all of the alternatives. Further, it is not the function of a TT class to go into depth on any other

modality than TT. It would be confusing to the student to intermingle therapies. TT is only one option among many; this would be the perspective of any teacher or practitioner.

2. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?

Yes, there should be national standards of for CAM practices and products. Standards, certification and/or credentialing would be done by the official organization that has a full understanding of the CAM therapy. National Standards and certification should apply to all individuals who practice or teach the modality, especially in a hospital, healthcare facility, and private practice or for compensation.
The application would be directed to and credentialing implemented by the appropriate organization for each CAM therapy.

3. Should the numerous energy healer organizations come together to form "a community?" If so, how and by whom should that "community" be formed?

No, the energy healer organizations should not form a "community". You can not lump different energy modalities together. Each is separate and distinct. IT MUST BE UNDERSTOOD THAT ALL ENERGY HEALING IS NOT ALIKE. You begin to muddy the waters for the consumer and in educating the health care professionals and the general public if this is done. Each form of energy healing needs to stand on its own research and not on already proven and established healing modalities that are not even related in their approach, program or process. In addition, there is already sharing through professional journals and the many conferences held throughout the United States.

4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
There should be modality specific guidelines and standards of practice set by the professional organizations of each modality. The modality specific organization is best equipped to do so. They are the experts in the modality history, education, practice and research with it. As for condition specific guidelines, one can not do that with TT as it is based on and individualized assessment. While two people may have the same "condition", energetically their treatments might look differently. It takes away from being client focused. Healing is about treating the whole person and we are each different and unique. As one practices TT for a period of time and attends the advanced workshops, information is shared on what different practitioners have found helpful in certain clinical situations, but it may not be the primary focus each client needs.

5. Are your members concerned about malpractice liability associated with providing CAM practices and products?

Each modality has to be considered individually. This is a difficult question for NH-PAI as TT is a non-invasive technique. The TT Therapist works mostly in the client/patient's energy field and sometimes does gentle hands on work. There have been no problems with TT in the almost 30 years it has been in existence. However, some of our members feel the need for malpractice insurance in this litigious society and others do not. There is a double-edged sword to malpractice insurance for CAM therapies. If there is no insurance, then there is no money to be sought after. If malpractice insurance comes to be, then it is feeding into the possibility of dramatically increased lawsuits which has occurred in the past 20 years in conventional/western medicine. Question 6 will continue NH-PAI's response to this question.

6. Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?

As stated above, TT has little, if any risk when it TT is the only CAM therapy used and the individual is well educated in using the intervention.

There are possible risks to CAM. There is a lack of credentialing in many modalities and the proliferation of practitioners who say they practice a modality, but are not qualified to do so.
In particular, energy modalities have lumped together, and this is a particular problem because the practice of one often violates the conceptual basis of another and the rights of the uniformed client/patient 's are not receiving what they think they are.
There is need for more research and increased funding. Each CAM must be clearly defined with its own research. For example, several modalities have cited TT research as their own. Each of these modalities has a different conceptual basis, which are not compatible. When this is done, it misleads the uninformed, which is often the medical community. IT IS ESSENTIAL FOR EACH CAM TO HAVE INTEGRITY REGARDING THE RESEARCH OF THEIR OWN WORK/THERAPY.
Another risk is that the CAM practitioner demonstrates a negative attitude toward allopathic medicine
It is important that the CAM practitioner is part of the medical team. The patient is empowered to use Dr Krieger's "optional medicine" approach in which they choose from among the options of treatment.

7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?

Yes. The mechanism would be the same as that for allopathic medicine. This has not been addressed by healing organizations yet, but is an area, which deserves exploration and clarification.

8. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?

Full disclosure with the consent of the client/patient is most helpful and appropriate on both practitioner's parts.
A common problem lies in the fact that the patients/clients do not tell their conventional medicine provider that they are seeing or seeking a CAM provider out of fear that their doctor may react negatively.
The conventional medicine practitioner should communicate the same information that they would to a conventional medicine practitioner. BOTH are professionals in their area of expertise and all information relevant to the patient/client's wellbeing should be shared. The problem lies in the lack of respect some allopathic practitioners have for CAM. There needs to be massive education and appropriate CAM awareness should begin at the college, nursing and medical school levels.
Clients/patients need to be part of the team and not feel they need to discontinue one over the other.

9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Only CAM practitioners who meet the credentialing criteria of the official organization or accrediting body practice in healthcare facilities, hospitals, and private practice or for numeration.
There is Policy and procedure for the practice of each CAM where it is practiced.
The practitioners credentialing information should be available for the client.
Products should have proper labeling.
Better education of the healthcare providers and public about CAM.
More cooperation and referrals by allopathic practitioners to CAM practitioners they have checked out.
Many CAM practitioners will give them a free consult to experience the technique or process.
More research in CAM.
Increased access to CAM therapies by reimbursement from insurance companies, Medicaid and Medicare
Governments increased role in educating the public in the advantages, of self-responsibility, alternative/complementary modalities and choice.

Thank you again for inviting NH-PAI to participate in these hearings.

Feel free to contact me with any questions you may have. We will inform you via your web site registration if we will be able to have a representative from NH-PAI attend. Please keep us apprised of any other meetings and Commission activities

Sincerely,

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White House Commission on Complementary and Alternative Medicine Policy

Proposed Meeting Schedule*

DATE	SITE	TYPE	TOPIC
February 22-23, 2001	Washington, D.C.	WHC (4)	EDUCATION/TRAINING
March 16, 2001	Minneapolis, MN	Townhall (4)	
March 26-27, 2001	Washington, D.C.	WHC (5)	INFO DISSEMINATION and WELLNESS
May 14-15-16, 2001	Washington, D.C.	WHC (7)	RESEARCH II and REIMBURSEMENT
July 2-3, 2001	Washington, D.C.	WHC (8)	REVIEW INTERIM REPORT DRAFT
October 4-5, 2001	Washington, D.C.	WHC (9)	PROGRESS ON FINAL REPORT
December 6-7, 2001	Washington, D.C.	WHC (10)	REVIEW FINAL REPORT
March 2002	Washington, D.C.	WHC (11)	CLOSING EVENT

*This information, including dates and locations, may change based on recommendations from the Commission. Updates are posted on our website: http://whccamp.hhs.gov as soon as they become available.