White House Commission on Complementary And Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817-7707 tel. 301-435-7592, fax 301-480-1691; e-mail whccamp@mail.nih.gov Website www.whccamp.hhs.gov

Commissioners' Biographical Sketches

Dr. James S. Gordon, of Washington, DC, who will serve as Chair of the Commission, is currently the Director of the Center for Mind-Body Medicine. Previously, he chaired the Program Advisory Council at the Office of Alternative Medicine of the National Institutes of Health. In addition to maintaining a private practice in Psychiatry and Medicine, Dr. Gordon has been a Clinical Professor at the Georgetown University School of Medicine in the Departments of Psychiatry and Family Medicine since 1980. He is a member of the National Institute of Health's Cancer Advisory Panel and was the Director of a Special Study of Alternative Services for the President's Commission on Mental Health. He has written extensively on the subjects of psychiatry and alternative and holistic care, and serves on the Editorial Boards of Alternative andComplementary Therapies and Alternative Therapies in Health and Medicine. He received his A.B. from Harvard College and his M.D. from Harvard Medical School.

Dr. George M. Bernier, Jr., of Galveston, TX, is a hematologist/oncologist and is currently the Vice President for Education at the University of Texas Medical Branch. Previously, he was Vice President for Academic Affairs, Dean of Medicine, and a Professor of Medicine at the University of Texas. Dr. Bernier has held academic appointments at the University of Pittsburgh, Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire, and at Case Western Reserve University in Cleveland, Ohio. He has published numerous articles and abstracts, and several books. He received a B.A. degree from Boston College and a M.D. degree from Harvard University.

Dr. David E. Bresler, of Los Angeles, California, is one of the first contemporary American scientists to study and research acupuncture, guided imagery, and other mind/body approaches. As a professor in the UCLA Departments of Anesthesiology, Gnathology/Occlusion and Psychology, he applied his findings to treating clinical problems that did not respond well to conventional care, beginning with chronic pain. As the Founder and Executive Director of the UCLA Pain Control Unit, he and his team created the first multi-disciplinary, university-based chronic pain program in America. Dr. Bresler has authored or co-authored numerous publications, as well as twenty books and workbooks. Currently, Dr. Bresler serves as Associate Clinical Professor of Anesthesiology at the UCLA School of Medicine, Executive Director of the Bresler Center, Clinical Consultant to the UCLA Pain Medicine Center, Dean of Mind/Body/Spirit of the University of Integrated Studies, and Co-Director of the Academy for Guided Imagery. Dr. Bresler received his B.A. from Brandeis University, his M.A. from Bryn Mawr College, and his Ph.D. from UCLA. He received his Certificate in Acupuncture from the Institute for Taoist Studies.

Mr. Thomas Chappell, of Kennebunk, ME, is the co-founder and CEO of Tom's of Maine, which he co-founded with his wife Kate in 1970. It is a company that produces innovative, natural personal products and natural wellness products in a caring and creative work environment. Mr. Chappell is founder and CEO of the Saltwater Institute, a learning institute of leaders seeking to integrate their value into their personal and professional lives. He is active in many philanthropic organizations, among them an Advisory Council member for the Center for Study of Values in Public Life at Harvard Divinity School, Harvard Divinity School Dean's Council, and a Board Member of the Nature Conservancy of Maine. He has written two books, The Soul of a Business and Managing Upside Down. Mr. Chappell received his B.A. from Trinity College and his Master's in Theology from the Harvard Divinity School.

Dr. Effie Poy Yew Chow, of San Francisco, CA, is the founder of the East West Academy of Healing Arts in 1973 and, more recently, The EWAHA Qigong Institute, the American Qigong Association, and the World Qigong Federation. She is the recipient of over twenty awards including "The Humanitarian of the Year 1999" and the "Visionary of the Decade 2000" awards. She has been the only Qigong Grandmaster and acupuncturist involved in the development of national health policies within DHHS. She was also involved in the first Ad Hoc Advisory Panel of the Office of Alternative Medicine at NIH. She has made over two hundred and fifty media appearances and interviews in the area of complementary and alternative medicine. Dr. Chow received her training in Traditional Chinese Medicine and Qigong in China, Hong Kong, Taiwan, Canada, and the United States. She is a registered public health and psychiatric nurse and has received a Master's degree and a Ph.D.

Mr. George Thomas DeVries, III, of Rancho Santa Fe, CA, is Chairman, President, CEO and co-founder of American Specialty Health, Inc. and its subsidiaries, American Specialty Health Plans, American Specialty Health Networks, American Specialty Health Systems, and Healthyroads.com. In his position, he manages complementary and alternative health care benefits, networks and services for over 100 health plans covering over 40 million Americans. American Specialty Health Plans is a license specialty health plan covering over 4 million Californians for chiropractic and acupuncture. American Specialty Health Systems is a health services intermediary in over 20 states serving over 1.7 million members. American Specialty Health Networks is a national health services organization serving over 35 million Americans and offering a national provider network of over 19,000 chiropractors, acupuncturists, massage therapists, dieticians, naturopaths, and fitness clubs. Healthyroads.com is a complementary healthcare consumer products company offering e-commerce and mail order. Mr. DeVries was the National Entrepreneur of the Year for Health Sciences in 2000. Mr. DeVries has published a number of articles and has lectured on alternative health care in managed care and third-party reimbursement. He received a B.A. from the University of California at San Diego.

Dr. William R. Fair, M.D., of Longboat Key, FL, was, until recently, the Florence and Theodore Baumritter/Enid Ancell Chair of Urology, and was Chief of the Urology Service at Memorial Sloan-Kettering Cancer Center in New York City. Currently, he is Emeritus Professor of Urology at the Joan and Sanford I. Weill Medical College of Cornell University and Member Emeritus at Memorial Sloan-Kettering. Dr. Fair serves on the Cancer Advisory Panel for the National Center for Complementary and Alternative Medicine. He is the Editor-in-Chief of Molecular Urology and the Associate Editor of Alternative Therapies in Health and Medicine, and on the editorial boards of other highly respected journals. He has published extensively in the areas of urology and oncology. He chairs the Committee on Complementary and Alternative Medicine of the American Urological Association, and is Chairman of the Clinical Advisory Board of Haelth, LLC. Dr. Fair received his B.S. from the Philadelphia College of Pharmacy and Science and his M.D. from Jefferson Medical College.

Dr. Joseph J. Fins, of New York, NY, is an internist and Director of Medical Ethics at New York Weill Cornell Medical Center of New York - Presbyterian Hospital, Associate Professor of Medicine and Medicine in Psychiatry at the Joan and Sanford I. Weill Medical College of Cornell University, Associate Professor in the Program in Clinical Epidemiology and Health Services Research at Weill Cornell Graduate School of Medical Sciences, and Associate for Medicine at The Hastings Center. He lectures extensively and has written widely in the field of Medical Ethics. Dr. Fins received his B.A. from Wesleyan University and his M.D. from Cornell University Medical College.

Dr. Veronica Gutierrez, of Lake Stevens, Washington, practices with Gutierrez Family Chiropractic. She is a professional member of the World Chiropractic Alliance, serving on the Board of Directors. She serves as Chair of the Council on Women's Health and Director of Programs in Public Policy. Dr. Gutierrez has been very active in the chiropractic community, serving on many boards and commissions. She has received numerous awards in her profession, including awards from the Chiropractic Society of Washington, the Straight Chiropractic Academic Standards Association, and the International Chiropractic Association. Dr. Gutierrez received her Doctor of Chiropractic from Palmer College of Chiropractic and did post-graduate work at Cleveland College of Chiropractic.

Dr. Wayne B. Jonas, of Alexandria, VA, is currently a member of the Department of Family Medicine of the Uniformed Services University of the Health Sciences F. Edward Hebert School of Medicine. Previously, Dr. Jonas served as the Director of the Office of Alternative Medicine for the National Center for Complementary and Alternative Medicine at the National Institutes of Health. Prior to that, he served as the Director of the World Health Organization Collaborating Center for Traditional Medicine. He has authored and co-authored numerous publications on alternative and homeopathic treatment and care. Some of his current research includes projects in environmental toxicology, neurotoxicology, stroke, and biofield healing. Dr. Jonas received a B.A. from Davidson College and a M.D. from Bowman Gray School of Medicine.

Sister Charlotte Rose Kerr, R.S.M., of Baltimore, MD, is a Registered Nurse, a Practitioner of Traditional Acupuncture and, since 1977 a Senior Faculty Member at the Traditional Acupuncture Institute. Previously, she was an Assistant Professor of Nursing at the University of Maryland School of Nursing. Sister Kerr has been a member of the Advisory Council of the National Institutes of Health (NIH) Alternative Medicine Program. She has spent several summers in Europe, studying such subjects as Theology and Healing. In her work, Sister Kerr emphasizes the integration of Western traditional medicine and complementary healing methods. Sister Kerr received her B.S.N. from the University of Maryland School of Nursing. She received her Master's Degree in Public Health from the University of North Carolina and another Master's Degree in acupuncture from the College of Traditional Chinese Medicine, U.K.

Ms. Linnea Larson, of Oak Park, Illinois, is Associate Director of West Suburban Health Care (WSHC), Center for Integrative Medicine in Oak Park. Previously, she was the Behavioral Science Coordinator at WSHC Family Practice Residency Program. She was a clinical social worker at St. John's Hospital in Springfield, Illinois, where she provided inpatient and home hospice services and was also associated with the St. John's Center for Mind-Body Medicine. She also has worked as a family therapist and as a lecturer at the University of Illinois at Springfield. Ms. Larson received a B.A. from Knox College and a M.S.W. from the University of Illinois at Urbana-Champaign.

Dr. Tieraona Low Dog, of Corrales, New Mexico, currently serves as the Medical Director for the Tree House Center of Integrative Medicine in Albuquerque. With more than twenty years in the field of botanical medicine, she was recently elected to serve as Chairperson for the Dietary Supplements and Botanicals Expert Panel for the United States Pharmacopoeia. Dr. Low Dog received her medical degree from the University of New Mexico School of Medicine. She is part of the core faculty for Columbia University's Botanical Medicine Course for Physicians. Dr. Low Dog is currently working with Beth Israel on the development of a continuing medical education program on herbal medicine for physicians. She frequently lectures on the subject of herbal medicine. In 1998, she received the International Martina de la Cruz award for her work with indigenous remedies.

Dr. Dean Ornish, of Sausalito, CA, is one of the founders, and the president and director of the non-profit Preventive Medicine Research Institute. He is Clinical Professor of Medicine at the University of California, San Francisco, and a founder of the Osher Center for Integrative Medicine there. He was the first to prove that heart disease is reversible by changing diet and lifestyle. He has published many books and academic papers and has received numerous awards in recognition of his work. Dr. Ornish received a B.A. from the University of Texas and completed his medical training at the Baylor College of Medicine in Houston, Harvard Medical School, and the Massachusetts General hospital. He was a clinical fellow in medicine at the Harvard Medical School. Dr. Ornish was recognized by Life magazine as "one of the 50 most influential members of his generation."

Dr. Conchita M. Paz, of Las Cruces, NM, has maintained a private practice, in which she specializes in family medicine, for ten years. Currently, she serves as a part-time faculty member at the University of New Mexico School of Medicine and at the Southern New Mexico Family Practice Residency Program. She was Chairperson of the Family Practice Department and serves on a number of committees at Memorial Medical Center. Dr. Paz received her B.S. and M.D. degrees from the University of New Mexico

Joseph E. Pizzorno, Jr., N.D., of Seattle is one of the world's leading authorities on science-based natural medicine. A physician, educator, researcher, and expert spokesperson, Dr. Pizzorno is co-founder and founding president of Bastyr University, the first fully accreditated, multidisciplinary university of natural medicine in the United States. Dr. Pizzorno is the author of Total Wellness and co-author of the Textbook of Natural Medicine and the Encyclopedia of Natural Medicine. In 1996, he was appointed to the Seattle/King County Board of Health, the first natural medicine practitioner in the country to receive such appointment. In 1999, Dr. Pizzorno was elected Chair of the American Public Health Association Special Primary Interest Group on Complementary and Alternative Medicine. He has been licensed as a naturopathic physician in Washington State since 1975. Dr. Pizzorno is now President Emeritus and Senior Advisor to the President of Bastyr University. In September 2000, the Cancer Treatment Centers of America recognized Dr. Pizzorno as Humanitarian of the Year. He currently travels worldwide, lecturing and promoting science-based natural medicine and integrative healthcare. He also co-founded a company to bring natural medicine concepts to corporate health promotion programs.

Mr. Buford L. Rolin, of Atmore, AL, has been the Health Administrator for the Poarch Band of Creek Indians since 1984. He is a member of the State of Alabama Public Health Advisory Board and a member of the Board of Directors of the Creek Indian Heritage Memorial Association. Mr. Rolin is currently the Chairman of the Creek Indian Arts Council. He is the former Chairman of the National Indian Health Board, and he still serves as a member of the Executive Committee and as a Member-At-Large. He has received several awards from the National Indian Health Board, and he has also received a Lifetime Achievement Award from the Poarch Band of Creek Indians. Mr. Rolin attended the Health Services Administrators Development Program at the School of Community and Allied Health of the University of Alabama and Pensacola Junior College.

Ms. Julia Scott, of Washington, DC, is Past President of the National Black Women's Health Project (NBWHP), a national membership organization that focuses on wellness, self-help, and health advocacy. Previously, she was Director of the Public Policy and Education Office of NBWHP. Ms. Scott was Special Assistant to the President and Coordinator of the Adolescent Pregnancy Child Watch at the Children's Defense Fund. She has directed and administered to several foundations and community health agencies and has written numerous articles on African American Women's health. Ms. Scott was educated in nursing at the Waterbury Hospital School of Nursing.

Dr. Xiao Ming Tian, of Bethesda, Maryland, is Director of the Academy of Acupuncture and Chinese Medicine and Wildwood Acupuncture Center. Dr. Tian is currently conducting a National Institute of Health (NIH) supported clinical trial with Georgetown University Medical School to treat fibromyalgia patients using acupuncture. He has completed many research projects on the use of Chinese herbal medicine and dietary supplements to treat and prevent arthritis, sports injuries, and fibromyalgia, in collaboration with NIH and the U.S. Department of Agriculture Nutrition Center. In 1991, Dr. Tian was the first person to be appointed a Clinical Consultant of Acupuncture to the NIH medical staff. He is an Adjunct Assistant Professor of Preventive Medicine at the United States Uniformed Health Service. Dr. Tian is the President of the American Association of Chinese Medicine. He is also the Honorary Director of the China Association of Traditional Chinese Medicine and Vice President of The International Academy of Medical Qigong, both in Beijing, China. He currently serves as an advisor to World Health Organization and Pan-American Health Organization on traditional medicine. Dr. Tian received his Medical Degree from Beijing Medical University and was a Ph.D. Research Fellow at NIH.

Dr. Donald W. Warren, of Clinton, Arkansas, currently practices general dentistry, which includes dental cranial osteopathy, an alternative and complementary approach to health; temporomandibular joint dysfunction treatment, an alternative treatment for head, neck and facial pain and orthodontics/orthopedics. Since 1989, Dr. Warren has presented seminars on dental cranial osteopathy, temporomandibular joint dysfunction treatment, contact reflex analysis and designed clinical nutrition, and correct dental occlusion. Since 1999, these seminars have been accredited by the Academy of General Dentistry. He also instructed a hands-on clinic at the Texas College of Osteopathic Medicine, hosted by the Sutherland Cranial Teaching Foundation. Dr. Warren has taught in the United States, the United Kingdom, and Australia. Dr. Warren received a B.A. from Hendrix College and a D.D.S. from the University of Tennessee College of Dentistry. Since then, he has continued to study in his fields of expertise and is a diplomat of the American Board of Head, Neck and Facial Pain.

To Contact WHCCAMP:

Stephen C. Groft, Pharm.D.
Executive Director

Michele M. Chang, CMT, MPH
Executive Secretary

6701 Rockledge Drive
Suite 1010, MS 7707
Bethesda, Maryland 20817-7707
tel. 301- 435-7592 or 866-373-1124
fax 301 -480-1691
e-mail: whccamp@mail.nih.gov
website: whccamp.hhs.gov

WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

COMMISSION ROSTER
NOT FOR PUBLIC DISTRIBUTION (3/21/01)

CHAIRPERSON

James S. Gordon, M.D.
Director
The Center for Mind-Body Medicine
2934 Macomb Street, N.W.
Washington, DC 20008
TEL: 202-537-6837
FAX: 202-363-7247
E-MAIL: jsgordon@mindspring.com

COMMISSIONERS

George M. Bernier, Jr., M.D.
Vice President for Education
University of Texas Medical Branch
301 University Boulevard, Suite 1.116
Galveston, Texas 77555-0113
TEL: 409-772-1362
FAX: 409-772-1390
E-MAIL: gbernier@utmb.edu

David Bresler, Ph.D, LAc, OME,
Dipl.Ac. (NCCAOM)
Founder and Executive Director
The Bresler Center, Inc.
30765 Pacific Coast Hwy #355
Malibu, California 90265
TEL: 310-446-1717
FAX: 310-589-9523
E-MAIL: bresler@aol.com
Private line: 310-589-9333

Thomas Chappell
Co-Founder and President
Tom's of Maine, Inc.
P.O. Box 710
Kennebunk, Maine 04043
TEL: 207-985-2944
FAX: 207-985-3982
E-MAIL: Tom@toms-of-maine.com

Effie Poy Yew Chow, Ph.D., R.N.
DiplAc(NCCA), Qigong Grandmaster
President, East West Academy of
Healing Arts
530 Bush Street
Suite 104-202
San Francisco, California 94108
TEL: 415-788-2227
FAX: 415-788-2242
E-MAIL: eastwestqi@aol.com

George T. DeVries, III
CEO/President
American Specialty Health Plans
777 Front Street
San Diego, California 92101
TEL: 619-557-2205
FAX: 619-237-3838
E-MAIL: georged@ashn.com

William R. Fair, M.D.
435 L'Ambiance Drive, #806
Longboat Key, Florida 34228
TEL: 941-383-3240
CELL: 917-373-7703
FAX: 941-387-1346/631-267-0175
E-MAIL: Fairw@aol.com

Joseph J. Fins, M.D., F.A.C.P.
Associate Professor of Medicine
Weill Medical College of Cornell University
Director of Medical Ethics
New York Presbyterian Hospital-Cornell Campus
525 East 68th Street, F-173
New York, New York 10021
TEL: 212-746-4246
FAX: 212-746-8738
E-MAIL: jjfins@mail.med.cornell.edu

Veronica Gutierrez, D.C.
Gutierrez Family Chiropractic
3704 172nd Street, NE-Suite N
Arlington, Washington 98223
TEL: 360-658-3818
FAX: 360-651-2344
E-MAIL: Veronicapgdc@aol.com

Wayne B. Jonas, M.D.
Department of Family Medicine
Uniformed Services University of the Health Sciences
F. Edward Hebert School of Medicine
4301 Jones Bridge Road
Bethesda, Maryland 20814-4799
TEL: 301-295-9461
FAX: 301-295-3100
E-MAIL: wjonas@usuhs.mil

Charlotte R. Kerr, R.S.M.
Traditional Acupuncture Institute, Inc.
American City Building
10227 Wincopin Circle, Suite 100
Columbia, Maryland 21044
TEL: 410-997-3770, ext. 614
FAX: 410-964-3544

Linnea Signe Larson, LCSW, LMFT
455 Washington Blvd.
Oak Park, Illinois 60302
TEL: 708-445-1689
FAX: 708-763-8728
E-MAIL: linnealarson@mac.com

Tieraona Low Dog, M.D., A.H.G.
4840 Pan American Freeway, N.E.
Albuquerque, New Mexico 87109
TEL: 505-875-1312
FAX: 505-855-7725
E-MAIL: lowdogmd@aol.com

Dean Ornish, M.D.
President and Director
Preventive Medicine Research Institute
Clinical Professor of Medicine
University of California, San Francisco
900 Bridgeway, Suite 2
Sausalito, California 94965
TEL: 415-332-2525
FAX: 415-332-5730
E-MAIL: deanornish@aol.com

Conchita M. Paz, M.D.
1510 Altura Avenue
Las Cruces, New Mexico 88001
TEL: 505-522-5205
FAX: 505-522-9746
E-MAIL: cmapaz@totacc.com

Joseph E. Pizzorno, Jr., N.D.
President Emeritus, Bastyr University
4220 NE 135th St
Seattle, WA 98125
TEL: 206-361-4620
FAX: 206-368-8570
CELL: 206-849-8712
E-MAIL: drpizzorno@qwest.net

Buford L. Rolin
Poarch Band of Creek Indians
308 Forest Avenue
P.O. Box 19
Atmore, Alabama 36504
TEL: 334-368-9136
FAX: 334-368-3757
E-MAIL: buford@frontiernet1.net

Julia R. Scott
1306 Palmyra Lane
Bowie, MD 20716
TEL: 301-518 -2698
E-MAIL: jrsct6@cs.com

Xiaoming Tian, M.D., L.Ac
Director, Wildwood Acupuncture Center
Director, Academy of Acupuncture &
Chinese Medicine
Wildwood Medical Center
Bethesda, Maryland 20814
TEL: 301-530-5308 or 301-365-8170
FAX: 301-564-5808
E-MAIL: mingtian@aol.com

Donald W. Warren, D.D.S.
Diplomate of the American Board of Head,
Neck & Facial Pain
390 Factory Road
Clinton, Arkansas 72031
TEL: 501-745-4656
FAX: 501-745-6317
E-MAIL: drwarren@artelco.com

EXECUTIVE STAFF

White House Commission on
Complementary and Alternative Medicine
Policy
6701 Rockledge Drive
Suite 1010, MS-7707
Bethesda, Maryland 20817-7707
TEL: 301-435-7592
FAX: 301-480-1691
E-MAIL: WHCCAMP@mail.nih.gov
WEBSITE: http://whccamp.hhs.gov

Stephen C. Groft, Pharm.D.
Executive Director
TEL: 301-435-6199
E-MAIL: GroftS@mail.nih.gov

Michele M. Chang, C.M.T.,M.P.H.
Executive Secretary
TEL: 301-435-6232
E-MAIL: changm@mail.nih.gov

Joan Albrecht
Program Assistant
TEL: 301-435-6198/1-866-373-1124
E-MAIL: joana@mail.nih.gov

Corinne Axelrod, M.P.H.
Senior Program Analyst
TEL: 301-435-2212
E-MAIL: axelrodc@mail.nih.gov

Joseph M. Kaczmarczyk, D.O., M.P.H.
Senior Medical Advisor
TEL: 301-435-6197
E-MAIL: Kaczmajo@mail.nih.gov

Doris A. Kingsbury
Program Assistant
TEL: 301-594-1990
E-MAIL: Kingsbud@mail.nih.gov

Geraldine B. Pollen, M.A.
Senior Program Analyst
TEL: 301-435-6233
E-MAIL: gp13b@nih.gov

CONSULTANT STAFF

Kenneth D. Fisher, Ph.D.
Senior Scientific Advisor
TEL: 301-435-2213
E-MAIL: Fisherk@mail.nih.gov

Maureen Miller, RN, MPH
Senior Policy Analyst
TEL: 301-435-2213
E-MAIL: millemau@mail.nih.gov

Jim Swyers
Writer-Editor
E-MAIL: jpswyers@starpower.net

Minnesota Townhall Meeting

CAM

MINNESOTA CHAPTER 146A

COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTICES

146A.01 Definitions.

Subdivision 1. Terms. As used in this chapter, the following terms have the meanings given them.

Subd. 2. Commissioner. "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 3. Complementary and alternative health care client. "Complementary and alternative health care client" means an individual who receives services from an unlicensed complementary and alternative health care practitioner.

Subd. 4. Complementary and alternative health care practices. (a) "Complementary and alternative health care practices" means the broad domain of complementary and alternative healing methods and treatments, including but not limited to: (1) acupressure; (2) anthroposophy; (3) aroma therapy; (4) ayurveda; (5) cranial sacral therapy; (6) culturally traditional healing practices; (7) detoxification practices and therapies; (8) energetic healing; (9) polarity therapy; (10) folk practices; (11) healing practices utilizing food, food supplements, nutrients, and the physical forces of heat, cold, water, touch, and light; (12) Gerson therapy and colostrum therapy; (13) healing touch; (14) herbology or herbalism; (15) homeopathy; (16) nondiagnostic iridology; (17) body work, massage, and massage therapy; (18) meditation; (19) mind-body healing practices; (20) naturopathy; (21) noninvasive instrumentalities; and (22) traditional Oriental practices, such as Qi Gong energy healing.

(b) Complementary and alternative health care practices do not include surgery, x-ray radiation, administering or dispensing legend drugs and controlled substances, practices that invade the human body by puncture of the skin, setting fractures, the use of medical devices as defined in section 147A.01, any practice included in the practice of dentistry as defined in section 150A.05, subdivision 1, or the manipulation or adjustment of articulations of joints or the spine as described in section 146.23 or 148.01.

(c) Complementary and alternative health care practices do not include practices that are permitted under section 147.09,

clause (11), or 148.271, clause (5).

(d) This chapter does not apply to, control, prevent, or restrict the practice, service, or activity of lawfully marketing or distributing food products, including dietary supplements as defined in the federal Dietary Supplement Health and Education Act, educating customers about such products, or explaining the uses of such products. Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments.

Subd. 5. Office of unlicensed complementary and alternative health care practice or office. "Office of unlicensed complementary and alternative health care practice" or "office" means the office of unlicensed complementary and alternative health care practice established in section 146A.02.

Subd. 6. Unlicensed complementary and alternative health care practitioner. (a) "Unlicensed complementary and alternative health care practitioner" means a person who:

(1) either: (i) is not licensed or registered by a health-related licensing board or the commissioner of health; or

(ii) is licensed or registered by the commissioner of health or a health-related licensing board other than the board of medical practice, the board of dentistry, the board of chiropractic examiners, or the board of podiatric medicine, but does not hold oneself out to the public as being licensed or registered by the commissioner or a health-related licensing board when engaging in complementary and alternative health care;

(2) has not had a license or registration issued by a health-related licensing board or the commissioner of health revoked or has not been disciplined in any manner at any time in the past, unless the right to engage in complementary and alternative health care practices has been established by order of the commissioner of health;

(3) is engaging in complementary and alternative health care practices; and

(4) is providing complementary and alternative health care services for remuneration or is holding oneself out to the public as a practitioner of complementary and alternative health care practices.

(b) A health care practitioner licensed or registered by the commissioner or a health-related licensing board, who engages in complementary and alternative health care while practicing under the practitioner's license or registration, shall be regulated by and be under the jurisdiction of the applicable health-related licensing board with regard to the complementary and alternative health care practices.

HIST: 2000 c 460 s 9

146A.02 Office of unlicensed complementary and alternative health care practice.

Subdivision 1. Creation. The office of unlicensed complementary and alternative health care practice is created in the department of health to investigate complaints and take and enforce disciplinary actions against all unlicensed complementary and alternative health care practitioners for violations of prohibited conduct, as defined in section 146A.08. The office shall also serve as a clearinghouse on complementary and alternative health care practices and unlicensed complementary and alternative health care practitioners through the dissemination of objective information to consumers and through the development and performance of public education activities, including outreach, regarding the provision of complementary and alternative health care practices and unlicensed complementary and alternative health care practitioners who provide these services.

Subd. 2. Rulemaking. The commissioner shall adopt rules necessary to implement, administer, or enforce provisions of this chapter pursuant to chapter 14.

HIST: 2000 c 460 s 10

146A.025 Maltreatment of minors.

Nothing in this chapter shall restrict the ability of a local welfare agency, local law enforcement agency, the commissioner of human services, or the state to take action regarding the maltreatment of minors under section 609.378 or 626.556. A parent who obtains complementary and alternative health care for the parent's minor child is not relieved of the duty to seek necessary medical care consistent with the requirements of sections 609.378 and 626.556. A complementary or alternative health care practitioner who is providing services to a child who is not receiving necessary medical care must make a report under section 626.556. A complementary or

alternative health care provider is a mandated reporter under section 626.556, subdivision 3.

HIST: 2000 c 460 s 11

146A.03 Reporting obligations.

Subdivision 1. Permission to report. A person who has knowledge of any conduct constituting grounds for disciplinary action relating to complementary and alternative health care practices under this chapter may report the violation to the office.

Subd. 2. Institutions. A state agency, political subdivision, agency of a local unit of government, private agency, hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the office any action taken by the agency, institution, or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition an unlicensed complementary and alternative health care practitioner's privilege to practice or treat complementary and alternative health care clients in the institution or, as part of the organization, any denial of privileges or any other disciplinary action for conduct that might constitute grounds for disciplinary action by the office under this chapter. The institution, organization, or governmental entity shall also report the resignation of any unlicensed complementary and alternative health care practitioners prior to the conclusion of any disciplinary action proceeding for conduct that might constitute grounds for disciplinary action under this chapter or prior to the commencement of formal charges but after the practitioner had knowledge that formal charges were contemplated or were being prepared.

Subd. 3. Professional societies. A state or local professional society for unlicensed complementary and alternative health care practitioners shall report to the office any termination, revocation, or suspension of membership or any other disciplinary action taken against an unlicensed complementary and alternative health care practitioner. If the society has received a complaint that might be grounds for discipline under this chapter against a member on which it has not taken any disciplinary action, the society shall report the complaint and the reason why it has not taken action on it or shall direct the complainant to the office.

Subd. 4. Licensed professionals. A licensed health professional shall report to the office personal knowledge of any conduct that the licensed health professional reasonably believes constitutes grounds for disciplinary action under this chapter by any unlicensed complementary and alternative health care practitioner, including conduct indicating that the individual may be incompetent or may be mentally or physically unable to engage safely in the provision of services. If the information was obtained in the course of a client relationship, the client is an unlicensed complementary and alternative health care practitioner, and the treating individual successfully counsels the other practitioner to limit or withdraw from practice to the extent required by the impairment, the office may deem this limitation of or withdrawal from practice to be sufficient disciplinary action.

Subd. 5. Insurers. Four times each year as prescribed by the commissioner, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to unlicensed complementary and alternative health care practitioners or the medical joint underwriting association under chapter 62F shall submit to the office a report concerning the unlicensed complementary and alternative health care practitioners against whom malpractice settlements or awards have been made. The response must contain at least the following information:

(1) the total number of malpractice settlements or awards made;

(2) the date the malpractice settlements or awards were made;

(3) the allegations contained in the claim or complaint leading to the settlements or awards made;

(4) the dollar amount of each malpractice settlement or award;

(5) the regular address of the practice of the unlicensed complementary and alternative health care practitioner against whom an award was made or with whom a settlement was made; and

(6) the name of the unlicensed complementary and alternative health care practitioner against whom an award was made or with whom a settlement was made.

The insurance company shall, in addition to the above information, submit to the office any information, records, and files, including clients' charts and records, it possesses that tend to substantiate a charge that an unlicensed complementary and alternative health care practitioner may have engaged in conduct violating this chapter.

Subd. 6. Courts. The court administrator of district court or any other court of competent jurisdiction shall report to the office any judgment or other determination of the court that adjudges or includes a finding that an unlicensed complementary and alternative health care practitioner is mentally ill, mentally incompetent, guilty of a felony, guilty of a violation of federal or state narcotics laws or controlled substances act, or guilty of abuse or fraud under Medicare or Medicaid; or that appoints a guardian of the unlicensed complementary and alternative health care practitioner under sections 525.54 to 525.61 or commits an unlicensed complementary and alternative health care practitioner under chapter 253B.

Subd. 7. Self-reporting. An unlicensed complementary and alternative health care practitioner shall report to the office any personal action that would require that a report be filed with the office by any person, health care facility, business, or organization pursuant to subdivisions 2 to 5. The practitioner shall also report the revocation, suspension, restriction, limitation, or other disciplinary action against the practitioner's license, certificate, registration, or right of practice in another state or jurisdiction for offenses that would be subject to disciplinary action in this state and also report the filing of charges regarding the practitioner's license, certificate, registration, or right of practice in another state or jurisdiction.

Subd. 8. Deadlines; forms. Reports required by subdivisions 2 to 7 must be submitted not later than 30 days after the reporter learns of the occurrence of the reportable event or transaction. The office may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to ensure prompt and accurate reporting.

HIST: 2000 c 460 s 12

146A.04 Immunity.

Subdivision 1. Reporting. Any person, other than the unlicensed complementary and alternative health care

practitioner who committed the violation, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting a report to the office, for otherwise reporting to the office violations or alleged violations of this chapter, or for cooperating with an investigation of a report, except as provided in this subdivision. Any person who knowingly or recklessly makes a false report is liable in a civil suit for any damages suffered by the person or persons so reported and for any punitive damages set by the court or jury. An action requires clear and convincing evidence that the defendant made the statement with knowledge of falsity or with reckless disregard for its truth or falsity. The report or statement or any statement made in cooperation with an investigation or as part of a disciplinary proceeding is privileged except in an action brought under this subdivision.

Subd. 2. Investigation. The commissioner and employees of the department of health and other persons engaged in the investigation of violations and in the preparation, presentation, and management of and testimony pertaining to charges of violations of this chapter are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

HIST: 2000 c 460 s 13

146A.05 Disciplinary record on judicial review.

Upon judicial review of any disciplinary action taken by the commissioner under this chapter, the reviewing court shall seal the portions of the administrative record that contain data on a complementary and alternative health care client or a complainant under section 146A.03, and shall not make those portions of the administrative record available to the public.

HIST: 2000 c 460 s 14

146A.06 Professional cooperation; unlicensed practitioner.

Subdivision 1. Cooperation. An unlicensed complementary and alternative health care practitioner who is the subject of an investigation, or who is questioned in connection with an investigation, by or on behalf of the office, shall cooperate fully with the investigation. Cooperation includes responding

fully and promptly to any question raised by or on behalf of the office relating to the subject of the investigation, whether tape recorded or not; providing copies of client records, as reasonably requested by the office, to assist the office in its investigation; and appearing at conferences or hearings scheduled by the commissioner. If the office does not have a written consent from a client permitting access to the client's records, the unlicensed complementary and alternative health care practitioner shall delete in the record any data that identifies the client before providing it to the office. If an unlicensed complementary and alternative health care practitioner refuses to give testimony or produce any documents, books, records, or correspondence on the basis of the fifth amendment to the Constitution of the United States, the commissioner may compel the unlicensed complementary and alternative health care practitioner to provide the testimony or information; however, the testimony or evidence may not be used against the practitioner in any criminal proceeding. Challenges to requests of the office may be brought before the appropriate agency or court.

Subd. 2. Data.

(a) Data relating to investigations of complaints and disciplinary actions involving unlicensed complementary and alternative health care practitioners are governed by this subdivision and section 13.41 does not apply. Except as provided in section 13.39, subdivision 2, and paragraph (b), data relating to investigations of complaints and disciplinary actions involving unlicensed complementary and alternative health care practitioners are public data, regardless of the outcome of any investigation, action, or proceeding.

(b) The following data are private data on individuals, as defined in section 13.02:

(1) data on a complementary and alternative health care client;

(2) data on a complainant under section 146A.03; and

(3) data on the nature or content of unsubstantiated complaints when the information is not maintained in anticipation of legal action.

Subd. 3. Exchanging information. (a) The office shall establish internal operating procedures for:

(1) exchanging information with state boards; agencies, including the office of ombudsman for mental health and mental retardation; health-related and law enforcement facilities; departments responsible for licensing health-related occupations, facilities, and programs; and law enforcement personnel in this and other states; and

(2) coordinating investigations involving matters within the jurisdiction of more than one regulatory agency.

(b) The procedures for exchanging information must provide for the forwarding to the entities described in paragraph (a), clause (1), of information and evidence, including the results of investigations, that are relevant to matters within the regulatory jurisdiction of the organizations in paragraph (a). The data have the same classification in the hands of the agency receiving the data as they have in the hands of the agency providing the data.

(c) The office shall establish procedures for exchanging information with other states regarding disciplinary action against unlicensed complementary and alternative health care practitioners.

(d) The office shall forward to another governmental agency any complaints received by the office that do not relate to the office's jurisdiction but that relate to matters within the jurisdiction of the other governmental agency. The agency to which a complaint is forwarded shall advise the office of the disposition of the complaint. A complaint or other information received by another governmental agency relating to a statute or rule that the office is empowered to enforce must be forwarded to the office to be processed in accordance with this section.

(e) The office shall furnish to a person who made a complaint a description of the actions of the office relating to the complaint.

HIST: 2000 c 460 s 15

146A.07 Professional accountability.

The office shall maintain and keep current a file containing the reports and complaints filed against unlicensed complementary and alternative health care practitioners within the commissioner's jurisdiction. Each complaint filed with the office must be investigated. If the files maintained by the

office show that a malpractice settlement or award has been made against an unlicensed complementary and alternative health care practitioner, as reported by insurers under section 146A.03, subdivision 5, the commissioner may authorize a review of the practitioner's practice by the staff of the office.

HIST: 2000 c 460 s 16

146A.08 Prohibited conduct.

Subdivision 1. Prohibited conduct. The commissioner may impose disciplinary action as described in section 146A.09 against any unlicensed complementary and alternative health care practitioner. The following conduct is prohibited and is grounds for disciplinary action:

(a) Conviction of a crime, including a finding or verdict of guilt, an admission of guilt, or a no-contest plea, in any court in Minnesota or any other jurisdiction in the United States, reasonably related to engaging in complementary and alternative health care practices. Conviction, as used in this subdivision, includes a conviction of an offense which, if committed in this state, would be deemed a felony, gross misdemeanor, or misdemeanor, without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is made or returned but the adjudication of guilt is either withheld or not entered.

(b) Conviction of any crime against a person. For purposes of this chapter, a crime against a person means violations of the following: sections 609.185; 609.19; 609.195; 609.20; 609.205; 609.21; 609.215; 609.221; 609.222; 609.223; 609.224; 609.2242; 609.23; 609.231; 609.2325; 609.233; 609.2335; 609.235; 609.24; 609.245; 609.25; 609.255; 609.26, subdivision 1, clause (1) or (2); 609.265; 609.342; 609.343; 609.344; 609.345; 609.365; 609.498, subdivision 1; 609.50, subdivision 1, clause (1); 609.561; 609.562; 609.595; and 609.72, subdivision 3.

(c) Failure to comply with the self-reporting requirements of section 146A.03, subdivision 7.

(d) Engaging in sexual contact with a complementary and alternative health care client or former client, engaging in contact that may be reasonably interpreted by a client as sexual, engaging in any verbal behavior that is seductive or sexually demeaning to the patient, or engaging in sexual exploitation of a client or former client. For purposes of this paragraph, "former client" means a person who has obtained

services from the unlicensed complementary and alternative health care practitioner within the past two years.

(e) Advertising that is false, fraudulent, deceptive, or misleading.

(f) Conduct likely to deceive, defraud, or harm the public or demonstrating a willful or careless disregard for the health, welfare, or safety of a complementary and alternative health care client; or any other practice that may create danger to any client's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(g) Adjudication as mentally incompetent or as a person who is dangerous to self or adjudication pursuant to chapter 253B as chemically dependent, mentally ill, mentally retarded, mentally ill and dangerous to the public, or as a sexual psychopathic personality or sexually dangerous person.

(h) Inability to engage in complementary and alternative health care practices with reasonable safety to complementary and alternative health care clients.

(i) The habitual overindulgence in the use of or the dependence on intoxicating liquors.

(j) Improper or unauthorized personal or other use of any legend drugs as defined in chapter 151, any chemicals as defined in chapter 151, or any controlled substance as defined in chapter 152.

(k) Revealing a communication from, or relating to, a complementary and alternative health care client except when otherwise required or permitted by law.

(l) Failure to comply with a complementary and alternative health care client's request made under section 144.335 or to furnish a complementary and alternative health care client record or report required by law.

(m) Splitting fees or promising to pay a portion of a fee to any other professional other than for services rendered by the other professional to the complementary and alternative health care client.

(n) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

(o) Failure to make reports as required by section 146A.03 or cooperate with an investigation of the office.

(p) Obtaining money, property, or services from a complementary and alternative health care client, other than reasonable fees for services provided to the client, through the use of undue influence, harassment, duress, deception, or fraud.

(q) Undertaking or continuing a professional relationship with a complementary and alternative health care client in which the objectivity of the unlicensed complementary and alternative health care practitioner would be impaired.

(r) Failure to provide a complementary and alternative health care client with a copy of the client bill of rights or violation of any provision of the client bill of rights.

(s) Violating any order issued by the commissioner.

(t) Failure to comply with any provision of sections 146A.01 to 146A.11 and the rules adopted under those sections.

(u) Failure to comply with any additional disciplinary grounds established by the commissioner by rule.

(v) Revocation, suspension, restriction, limitation, or other disciplinary action against any health care license, certificate, registration, or right to practice of the unlicensed complementary and alternative health care practitioner in this or another state or jurisdiction for offenses that would be subject to disciplinary action in this state or failure to report to the office that charges regarding the practitioner's license, certificate, registration, or right of practice have been brought in this or another state or jurisdiction.

(w) Use of the title "doctor," "Dr.," or "physician" alone or in combination with any other words, letters, or insignia to describe the complementary and alternative health care practices the practitioner provides.

(x) Failure to provide a complementary and alternative health care client with a recommendation that the client see a health care provider who is licensed or registered by a health-related licensing board or the commissioner of health, if there is a reasonable likelihood that the client needs to be seen by a licensed or registered health care provider.

Subd. 2. Less customary approach. The fact that a complementary and alternative health care practice may be a less customary approach to health care shall not constitute the basis of a disciplinary action per se.

Subd. 3. Evidence. In disciplinary actions alleging a violation of subdivision 1, paragraph (a), (b), (c), or (g), a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same is admissible into evidence without further authentication and constitutes prima facie evidence of its contents.

Subd. 4. Examination; access to medical data. (a) If the commissioner has probable cause to believe that an unlicensed complementary and alternative health care practitioner has engaged in conduct prohibited by subdivision 1, paragraph (g), (h), (i), or (j), the commissioner may issue an order directing the practitioner to submit to a mental or physical examination or chemical dependency evaluation. For the purpose of this subdivision, every unlicensed complementary and alternative health care practitioner is deemed to have consented to submit to a mental or physical examination or chemical dependency evaluation when ordered to do so in writing by the commissioner and further to have waived all objections to the admissibility of the testimony or examination reports of the health care provider performing the examination or evaluation on the grounds that the same constitute a privileged communication. Failure of an unlicensed complementary and alternative health care practitioner to submit to an examination or evaluation when ordered, unless the failure was due to circumstances beyond the practitioner's control, constitutes an admission that the unlicensed complementary and alternative health care practitioner violated subdivision 1, paragraph (g), (h), (i), or (j), based on the factual specifications in the examination or evaluation order and may result in a default and final disciplinary order being entered after a contested case hearing. An unlicensed complementary and alternative health care practitioner affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the practitioner can resume the provision of complementary and alternative health care practices with reasonable safety to clients. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the commissioner shall be used against an unlicensed complementary and alternative health care practitioner in any other proceeding.

(b) In addition to ordering a physical or mental examination or chemical dependency evaluation, the commissioner

may, notwithstanding section 13.42; 144.651; 595.02; or any other law limiting access to medical or other health data, obtain medical data and health records relating to an unlicensed complementary and alternative health care practitioner without the practitioner's consent if the commissioner has probable cause to believe that a practitioner has engaged in conduct prohibited by subdivision 1, paragraph (g), (h), (i), or (j). The medical data may be requested from a provider as defined in section 144.335, subdivision 1, paragraph (b), an insurance company, or a government agency, including the department of human services. A provider, insurance company, or government agency shall comply with any written request of the commissioner under this subdivision and is not liable in any action for damages for releasing the data requested by the commissioner if the data are released pursuant to a written request under this subdivision, unless the information is false and the person or organization giving the information knew or had reason to believe the information was false. Information obtained under this subdivision is private data under section 13.41.

HIST: 2000 c 460 s 17

146A.09 Disciplinary actions.

Subdivision 1. Forms of disciplinary action. When the commissioner finds that an unlicensed complementary and alternative health care practitioner has violated any provision of this chapter, the commissioner may take one or more of the following actions, only against the individual practitioner:

(1) revoke the right to practice;

(2) suspend the right to practice;

(3) impose limitations or conditions on the practitioner's provision of complementary and alternative health care practices, impose rehabilitation requirements, or require practice under supervision;

(4) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the practitioner of any economic advantage gained by reason of the violation charged or to reimburse the office for all costs of the investigation and proceeding;

(5) censure or reprimand the practitioner;

(6) impose a fee on the practitioner to reimburse the

office for all or part of the cost of the proceedings resulting in disciplinary action including, but not limited to, the amount paid by the office for services from the office of administrative hearings, attorney fees, court reports, witnesses, reproduction of records, staff time, and expense incurred by the staff of the office of unlicensed complementary and alternative health care practice; or

(7) any other action justified by the case.

Subd. 2. Discovery; subpoenas. In all matters relating to the lawful activities of the office, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. Any person failing or refusing to appear or testify regarding any matter about which the person may be lawfully questioned or failing to produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the commissioner or by a subpoena of the commissioner to do so may, upon application to the district court in any district, be ordered to comply with the order or subpoena. The commissioner may administer oaths to witnesses or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process may be served upon a person it names anywhere within the state by any officer authorized to serve subpoenas or other process in civil actions in the same manner as prescribed by law for service of process issued out of the district court of this state.

Subd. 3. Hearings. If the commissioner proposes to take action against the practitioner as described in subdivision 1, the commissioner must first notify the practitioner against whom the action is proposed to be taken and provide the practitioner with an opportunity to request a hearing under the contested case provisions of chapter 14. If the practitioner does not request a hearing by notifying the commissioner within 30 days after service of the notice of the proposed action, the commissioner may proceed with the action without a hearing.

Subd. 4. Reinstatement. The commissioner may at the commissioner's discretion reinstate the right to practice and may impose any disciplinary measure listed under subdivision 1.

Subd. 5. Temporary suspension. In addition to any other remedy provided by law, the commissioner may, acting through a

person to whom the commissioner has delegated this authority and without a hearing, temporarily suspend the right of an unlicensed complementary and alternative health care practitioner to practice if the commissioner's delegate finds that the practitioner has violated a statute or rule that the commissioner is empowered to enforce and continued practice by the practitioner would create a serious risk of harm to others. The suspension is in effect upon service of a written order on the practitioner specifying the statute or rule violated. The order remains in effect until the commissioner issues a final order in the matter after a hearing or upon agreement between the commissioner and the practitioner. Service of the order is effective if the order is served on the practitioner or counsel of record personally or by first class mail. Within ten days of service of the order, the commissioner shall hold a hearing on the sole issue of whether there is a reasonable basis to continue, modify, or lift the suspension. Evidence presented by the office or practitioner shall be in affidavit form only. The practitioner or the counsel of record may appear for oral argument. Within five working days after the hearing, the commissioner shall issue the commissioner's order and, if the suspension is continued, schedule a contested case hearing within 45 days after issuance of the order. The administrative law judge shall issue a report within 30 days after closing of the contested case hearing record. The commissioner shall issue a final order within 30 days after receipt of that report.

Subd. 6. Automatic suspension. The right of an unlicensed complementary and alternative health care practitioner to practice is automatically suspended if (1) a guardian of an unlicensed complementary and alternative health care practitioner is appointed by order of a court under sections 525.54 to 525.61, or (2) the practitioner is committed by order of a court pursuant to chapter 253B. The right to practice remains suspended until the practitioner is restored to capacity by a court and, upon petition by the practitioner, the suspension is terminated by the commissioner after a hearing or upon agreement between the commissioner and the practitioner.

Subd. 7. Licensed or regulated practitioners. If a practitioner investigated under this section is licensed or registered by the commissioner of health or a health-related licensing board, is subject to the jurisdiction of the commissioner under section 146A.01, subdivision 6, paragraph (a), clause (1), item (ii), and the commissioner determines that the practitioner has violated any provision of this chapter, the commissioner, in addition to taking disciplinary action under

this section:

(1) may, if the practitioner is licensed or regulated in another capacity by the commissioner, take further disciplinary action against the practitioner in that capacity; or

(2) shall, if the practitioner is licensed or registered in another capacity by a health-related licensing board, report the commissioner's findings under this section, and may make a nonbinding recommendation that the board take further action against the practitioner in that capacity.

HIST: 2000 c 460 s 18

146A.10 Additional remedies.

Subdivision 1. Cease and desist. (a) The commissioner may issue a cease and desist order to stop a person from violating or threatening to violate a statute, rule, or order which the office has issued or is empowered to enforce. The cease and desist order must state the reason for its issuance and give notice of the person's right to request a hearing under sections 14.57 to 14.62. If, within 15 days of service of the order, the subject of the order fails to request a hearing in writing, the order is the final order of the commissioner and is not reviewable by a court or agency.

(b) A hearing must be initiated by the office not later than 30 days from the date of the office's receipt of a written hearing request. Within 30 days of receipt of the administrative law judge's report, the commissioner shall issue a final order modifying, vacating, or making permanent the cease and desist order as the facts require. The final order remains in effect until modified or vacated by the commissioner.

(c) When a request for a stay accompanies a timely hearing request, the commissioner may, in the commissioner's discretion, grant the stay. If the commissioner does not grant a requested stay, the commissioner shall refer the request to the office of administrative hearings within three working days of receipt of the request. Within ten days after receiving the request from the commissioner, an administrative law judge shall issue a recommendation to grant or deny the stay. The commissioner shall grant or deny the stay within five days of receiving the administrative law judge's recommendation.

(d) In the event of noncompliance with a cease and desist order, the commissioner may institute a proceeding in Hennepin

county district court to obtain injunctive relief or other appropriate relief, including a civil penalty payable to the office not exceeding $10,000 for each separate violation.

Subd. 2. Injunctive relief. In addition to any other remedy provided by law, including the issuance of a cease and desist order under subdivision 1, the commissioner may in the commissioner's own name bring an action in Hennepin county district court for injunctive relief to restrain an unlicensed complementary and alternative health care practitioner from a violation or threatened violation of any statute, rule, or order which the commissioner is empowered to regulate, enforce, or issue. A temporary restraining order must be granted in the proceeding if continued activity by a practitioner would create a serious risk of harm to others. The commissioner need not show irreparable harm.

Subd. 3. Additional powers. The issuance of a cease and desist order or injunctive relief granted under this section does not relieve a practitioner from criminal prosecution by a competent authority or from disciplinary action by the commissioner.

HIST: 2000 c 460 s 19

146A.11 Complementary and alternative health care client bill of rights.

Subdivision 1. Scope. All unlicensed complementary and alternative health care practitioners shall provide to each complementary and alternative health care client prior to providing treatment a written copy of the complementary and alternative health care client bill of rights. A copy must also be posted in a prominent location in the office of the unlicensed complementary and alternative health care practitioner. Reasonable accommodations shall be made for those clients who cannot read or who have communication impairments and those who do not read or speak English. The complementary and alternative health care client bill of rights shall include the following:

(1) the name, complementary and alternative health care title, business address, and telephone number of the unlicensed complementary and alternative health care practitioner;

(2) the degrees, training, experience, or other qualifications of the practitioner regarding the complimentary and alternative health care being provided, followed by the

following statement in bold print:

"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.";

(3) the name, business address, and telephone number of the practitioner's supervisor, if any;

(4) notice that a complementary and alternative health care client has the right to file a complaint with the practitioner's supervisor, if any, and the procedure for filing complaints;

(5) the name, address, and telephone number of the office of unlicensed complementary and alternative health care practice and notice that a client may file complaints with the office;

(6) the practitioner's fees per unit of service, the practitioner's method of billing for such fees, the names of any insurance companies that have agreed to reimburse the practitioner, or health maintenance organizations with whom the practitioner contracts to provide service, whether the practitioner accepts Medicare, medical assistance, or general assistance medical care, and whether the practitioner is willing to accept partial payment, or to waive payment, and in what circumstances;

(7) a statement that the client has a right to reasonable notice of changes in services or charges;

(8) a brief summary, in plain language, of the theoretical approach used by the practitioner in providing services to clients;

(9) notice that the client has a right to complete and current information concerning the practitioner's assessment and

recommended service that is to be provided, including the expected duration of the service to be provided;

(10) a statement that clients may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner;

(11) a statement that client records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law;

(12) a statement of the client's right to be allowed access to records and written information from records in accordance with section 144.335;

(13) a statement that other services may be available in the community, including where information concerning services is available;

(14) a statement that the client has the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs;

(15) a statement that the client has a right to coordinated transfer when there will be a change in the provider of services;

(16) a statement that the client may refuse services or treatment, unless otherwise provided by law; and

(17) a statement that the client may assert the client's rights without retaliation.

Subd. 2. Acknowledgment by client. Prior to the provision of any service, a complementary and alternative health care client must sign a written statement attesting that the client has received the complementary and alternative health care client bill of rights.

HIST: 2000 c 460 s 20

* NOTE: This section, as added by Laws 2000, chapter 460, *section 20, is effective July 1, 2001. Laws 2000, chapter 460, *section 67.

SUMMARY of MINNESOTA STATUTE 146A COMPLEMENTARY AND ALTERNATIVE HEALTHCARE FREEDOM OF ACCESS ACT

9/27/2000

146A.01 Definitions: Explains what Complementary and Alternative Health Care Practices ARE, what they are NOT, and who is an Unlicensed Complementary and Alternative Health Care Practitioner.

146A.02 Creates the Office of Unlicensed Complementary and Alternative Health Care Practice within the Minnesota Department of Health to investigate complaints and enforce disciplinary actions again practitioners for violations of prohibited conduct.

146A.025 Assures that existing laws regarding maltreatment of minors is followed.

146A.03 Establishes a duty to report violations to the Office of Unlicensed Complementary and Alternativ Health Care. Includes self-reporting.

146A.04 States conditions for immunity from liability for reporting violations of this chapter.

146A.05 States the data privacy status of disciplinary records for Court in the event of Judicial Review:

146A.06 Sets out the obligation of an Unlicensed Complementary and Alternative Health Care Practitione to cooperate with an investigation by the Office of Unlicensed Complementary and Alternative Health Care. Establishes data status of client, complainant, and investigative records

146A.07 States the Office's obligation to investigate and keep a file of complaints.

146A.08 Spells out 24 areas of prohibited conduct for Unlicensed Complementary and Alternative Health Care practitioners.

146A.09 Lists the actions that the Department of Health can take against practitioners when the Commissioner finds that a practitioner has violated a provision of this chapter.

146A.10 Gives additional remedies, including cease and desist orders and injunctive relief.

146A.11 States what must be included in the Complementary and Alternative Health Care Client Bill of Rights.

147.09(15) Amends MN Stat. 147.09 and exempts unlicensed complementary health care practitioners from the Board of Medical Practice Statute if they are practicing according to this statute

214.01 Sub 2 Amends MN Stat. 214.01 to include the office of unlicensed complementary and alternative heal care practice in the definition of what is a health-related licensing board.

Section 65: Section 65 of Chapter 460 Session Laws requires Dept. of Health to collect data and report back the legislature on the complaints received and actions taken under this chapter.

Section 67. Section 67 of Chapter 460 Session Laws states the effective Date of 147A to be July 1, 2001.

Prepared by Attorney Diane Miller. 1398 25th St. N.W. New Brighton. MN 55112

Recommendations to the White House Commission on Complementary and Alternative Medicine

Minnesota Natural Health Legal Reform Project

The Minnesota Natural Health Legal Reform Project is a grass-roots citizen-based group that works to ensure citizens' legal access to the health care provider and modality of their choice. In May of 2000, we succeeded in passing the *Complementary and Alternative Health Care Freedom of Access Bill*, which devised a creative new way to allow a broad range of health care practitioners to legally practice, thus ensuring maximum citizen choice in health care options.

The following are our findings and recommendations to the White House Commission on Complementary and Alternative Health Care Policy:

Regulation of Practitioners

Findings

- Every person has the basic right of self-determination and the right to make their own personal choices in the process of their healing. This decision is the most personal decision a person can make.

- Every person has the right to utilize the health care practitioner, treatment , or information source that he or she desires. Citizens have this right regardless of the practitioner's education, training and experience, and regardless of whether the treatment they seek is socially acceptable, well known, "scientifically proven" or generally recognized.

- Many natural health therapies have been used since the beginning of time, and tend to be safe, non toxic and non-invasive. These natural healing arts should be as accessible as possible to all citizens.

- Just as citizens' rights to have freedom of information requires freedom of the press, and just as our rights to practice the religion we choose requires freedom of religious organizations to operate, so the right of citizens to access the healing modality of their choice requires the right of practitioners to be able to practice their trades.

- The biggest obstacle to the use of natural therapies has been the passage in the early 20th Century of medical statutes in almost every state which prohibit "the unlicensed practice of medicine," thus making it illegal for most people to practice any of the healing arts unless they were a licensed physician.

- The medical statutes generally developed an overly broad definition of the practice of medicine. Many are similar to the statute in Minnesota , Statute 147 Subdivision 3(3) which states that anyone who *"offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, or defect of any person;"* is practicing medicine and must be licensed to do so.

- Before these licensing laws were passed in America, many people assisted others in their health by using herbs, foods, homeopathy, water therapies, and many other healing methods. However, as medical licensing statutes evolved, it eventually became a criminal offense - the "unlicensed practice of medicine" - to help people get well, or to even prevent disease, unless one was medically licensed. As a result, what we today call "complementary and alternative " forms of health care almost disappeared entirely from America in the early 20th Century.

- The role of government regulation is to protect citizens' rights to individual choice and autonomy and to protect them from harm. The public interest is served when citizens have the freedom to make their own choices and the widest possible variety and diversity of options is available to them.

- Licensure works by mandating a required type and extent of education, and restricts individuals who have not met those requirements from practicing. Licensure is not appropriate for many of the healing arts, as it sets up a false assumption: that specific academic criteria are required for an individual to assist someone with the age-old wisdoms of health care.

- Because licensure is so restrictive, it should only be used when necessary to protect the public.

- Licensure requests are often brought for other reasons, such as a desire for third-party reimbursement. Although often advocated for as required to protect the public, typically requests for licensure have been brought by groups of practitioners, not the public asking for protection

- There is a need for legislation to allow unlicensed providers of complementary and alternative health care to practice without fear of criminal prosecution for "practicing medicine without a license."

- Legislative reform can provide a regulatory framework for a broad range of natural health practitioners without requiring licensure.

- Licensed health practitioners also face restrictions, in the form of inability to practice outside of the prevailing standard of care. Practitioners who use therapies that are different than the prevailing standards face the threat of loss of their license, even if the care they use causes no harm.

- The necessity of adhering to the "prevailing standard of care" often inhibits licensed practitioners from utilizing complementary and alternative therapies for their clients.

- Licensed practitioners who are sanctioned for practicing complementary and alternative therapies often feel unfairly treated due to the broad powers of the licensing boards.

- Legal reform is necessary to open up ways for these providers to practice outside of their standard of care, while providing citizens maximum information regarding options in their care.

Recommendations

- Freedom of access legislation, which allows unlicensed providers to continue providing the healing arts to citizens, should be introduced in every state. This legislation should:

  provide a regulatory framework for the broad range of healing practitioners without requiring licensure.

  provide an exemption from the medical statute for those practitioners under the regulatory framework, where the medical statute makes it illegal to practice

- The Minnesota Natural Health Legal Reform Project Recommends that Minnesota Statute 146A, the Complementary and Alternative Health Care Freedom of Access Act, be referred to

- There is a need for government funding for research in complementary and alternative therapies, particularly because the typical funding of research relies on profits from the development of procedures or substances which can be patented. However, the natural healing arts and healing substances, being not patentable, do not receive this financial support.

- Access to complementary and alternative therapies should not be dependant on documentation and research patterned after types of research done in conventional medicine. Citizens often find success in using health care methods that have not been researched, and they make evaluations based on their own experiences. They should continue to have access to the modalities they prefer.

- High standards of accountability regarding conflict of interest are needed by government regulatory agencies such as the FDA. Representatives of corporations which manufacture and market vaccines or pharmaceutical drugs should not be on FDA panels which evaluate and approve these products.

- There should be no "revolving door" arrangements allowing an employee or board member of a regulated industry to secure a position with the agency which regulates its products.

CONSUMER ACCESS/REIMBURSEMENT

Findings

- The first requirement for citizen access to the healing arts is that a way be found for the services to be legally practiced. As consumers, we feel our innovative new Minnesota Statute 146a effectively addresses that question for unlicensed practitioners.

- The use of natural therapies through health promotion and disease intervention is often extremely cost-effective and, if implemented, could help to lower health-care costs.

Recommendations

- Citizens with third-party coverage should be able to choose the type of health care and the practitioners that they prefer. The broad range of the healing arts and of practitioners should be an option for all citizens.

- Medical savings accounts and other ways of defining contributions available, rather than defining benefits covered, can help to give citizens more control on how to utilize their health care dollars, while avoiding restrictions on what can be covered.

- We believe there is a need for creative and new ways of looking at reimbursement. The past reliance on government regulation and educational standards does not fit well with the nature of complementary and alternative therapies. Holistic healing is a different paradigm from conventional treatments, and access to third-party coverage also requires a new paradigm.

- Health care plans need to be developed that put the primary concern on meeting the health care needs of the citizens, not the economic interests of the HMO or other providers.

DELIVERY OF RELIABLE AND USEFUL INFORMATION TO THE PUBLIC

- The dissemination of information to the public has been stymied by the regulatory climate which made the "unlicensed practice of medicine" a criminal offense, and which made it

impossible for licensed health care practitoners to practice outside of the "prevailing standard of care." This legal situation has created a climate of fear, in which practitioners are reluctant to write or speak publicly about their therapies for fear of prosecution. This is a freedom of speech issue, as well as a freedom of practice issue.

- The first step in increasing the flow of information on healing therapies is to make a way for the therapies to be legally practiced. In Minnesota, because of the imminent implementation of the new Statute 146a, practitioners will be able to publicly give out truthful information without fear of arbitrary prosecution.

- There is a need for more factual and unbiased media coverage of complementary and alternative health care methods.

- There is a need for education of conventional medical practitioners regarding complementary and alternative health care practices. This would allow more free flow of information in both directions, to the benefit of consumers. Conventional practitioners could then provide their clients with information about other healing options, and referrals to alternative providers.

Even the Founding Fathers recognized the importance of citizen health freedom. Benjamin Rush, M.D., one of the signers of the Declaration of Independence, wrote:

"The Constitution of this Republic should make special provision for Medical Freedom as well as Religious Freedom... To restrict the art of healing to one class of men and deny equal privileges to others will constitute a bastille [prison] of medical science. All such laws are un-American and despotic."

White House Commission
Complementary and Alternative Medicine
Minneapolis, MN
March 16, 2001

Minnesota Complementary and Alternative Health Freedom of Access Act and Professional Nursing Practice

Shirley A. Brekken
Executive Director
Minnesota Board of Nursing

The Minnesota Complementary and Alternative Health Freedom of Access Act (Minnesota Statutes 146A) provides for which practitioners will be able to practice as unlicensed complementary and alternative health care practitioners under the jurisdiction of the Department of Health, definitions, reporting obligations, grounds for disciplinary action, and a Client Bill of Rights. The Minnesota Nurse Practice Act provides for which individuals are able to practice as a licensed nurses under the jurisdiction of the Board of Nursing, definitions, reporting obligations, and grounds for disciplinary action. Neither law clearly provides for how a licensed nurse may practice complementary and alternative health care. This lack of legal clarity has contributed to confusion and concern for nurses who provide complementary and alternative health care practices.

The definition of complementary and alternative health care practices included in the law is not descriptive and explanatory but is an inclusive, but not limited to, list of practices that have been usually recognized as outside the mainstream of health care. The definitions of nursing in the Nurse Practice Act do not include these complementary and alternative modalities. This lack of inclusion in the legal definitions of nursing and the lack of standardization for such practices in nursing education curricula and competence measurement mean complementary and alternative health care practices are not within the legally-defined scope of nursing practice in Minnesota.

Two provisions in the Complementary and Alternative Health Freedom of Access Act further contribute to the confusion of nurses who practice complementary and alternative therapies. The law defines an unlicensed complementary and alternative health care practitioner as a person who is not licensed or registered by a health-related licensing board or does not hold oneself out to the public as licensed or registered by a health-related licensing board when engaging in complementary and alternative health care practices. The effect is that a nurse may practice as an unlicensed complementary and alternative health care practitioner under the jurisdiction of the Department of Health; however, if the individual, who is also a nurse, identifies oneself as a nurse, the individual is subject to the jurisdiction of the Board of Nursing. And, as described, the legal definition of nursing does not include the practice of complementary or alternative

health care practices. The Client Bill of Rights requires the unlicensed complementary and alternative health care practitioner to divulge the degrees, training, experience or other qualifications of the practitioner to provide that complementary or alternative care. Does this require the unlicensed complementary and alternative health-care practitioner to reveal education as a nurse? And if one identifies nursing education, is the effect that the individual is holding oneself out as a nurse? Nurses often ask if they may identify their RN title or education as a nurse on business cards. Additionally, nurses occasionally provide complementary or alternative therapy in a hospital setting where they also provide traditional health care.

The Client Bill of Rights provided to the client must declare "THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. " While basic nursing education programs may include learning to complement traditional treatments with techniques such as focused breathing and relaxation, massage, guided imagery, music, humor and distraction, few nursing programs include such alternative practices as herbology, homeopathy, colostrum therapy or Qi gong energy healing.

A license to practice nursing provides to the public a confidence that the nurse has met certain education and competence requirements. Complementary and alternative health therapies are not usually included in those expectations. Many nurses who practice complementary and alternative health care posit that preparation and experience as a nurse enhance their ability to practice a complementary or alternative health practices. However, one does not have to be a nurse to practice the same complementary or alternative therapies.

The Board of Nursing is aware the confusion and concerns of nurses who practice complementary and alternative therapies. Integration of these modalities into the conventional health care system is expected. The challenge to "conventional" regulation is to provide the consumer with clear and useful information regarding expectations of licensed nurses and to provide data to nurses in a similar manner.

Thank you for the opportunity to testify at this White House Commission.

Shirley A. Brekken
Executive Director
Minnesota Board of Nursing
612-617-2296
shirley.brekken@state.mn.us

Minnesota Natural Health Coalition

What's New

Text of Bill

Our History

Newsletters

Other Articles

Links

Home Page

May 30, 2000
Minnesota's Health Care Freedom Bill Signed into Law

In a world looking for freedom of access to alternative health care, Minnesota has found an answer. On May 11th, Governor Jesse Ventura signed the Complementary and Alternative Health Care Freedom of Access bill into law. With that signing, Minnesota protected freedom of access to health care as a basic freedom that people enjoy, along with freedom of speech and freedom of the press. Few choices are so fundamental and important as is the choice of how we shall recover from illness or improve health.

Freedom of Access
The successful reform caps a grassroots campaign, waged over several years, to better assure consumer access to the kind of health care that is wanted. The bill's enactment marks a step forward for protecting consumer access not only in Minnesota, but also throughout the land. The bill has been hailed as a bellweather signaling a long overdue recognition of freedom to practice for alternative health care practitioners as well. A consumer's freedom of access is dependent on the practitioner's freedom to practice, of course, much as the public's freedom of access to information rests on the writer's freedom to write freely and without suppression by state laws or actions. For many, the unfair suppression of health care practices is just as troubling and unacceptable as would be the state's censorship of books or of free speech.

How the Movement Started
The health freedom movement in Minnesota was galvanized in the mid-90s by high profile legal actions taken against several of the state's most prominent alternative health care practitioners, both licensed and unlicensed. One case involved St. Paul naturopathic doctor Helen Healy, who was charged with "practice of medicine" without a license. Despite the absence of consumer complaints and even despite the absence of any allegations of patient harm, the state's Medical Board sought to shut down Healy's practice immediately and permanently. The public outcry helped save Healy from being shut down; she settled out of court before her trial. But it also helped spur a new thirst for greater protection of consumer freedom of access and a desire to affirm the practitioner's right to practice with fairer treatment

under the law. A citizen "legal committee" that researched the legal obstacles to health freedom eventually became the nonprofit Minnesota Natural Health Legal Reform Project, which spearheaded the legal reform effort.

The Overly Broad Definition

The crux of the problem for all unlicensed practitioners, including Helen Healy, is the overly broad definition of the "practice of medicine." The sweeping definition includes anyone who undertakes to diagnose, correct, treat or even prevent any disease, illness, pain or infirmity by any manner or means; such people are practicing medicine, according to existing law, and must be licensed medical doctors. Nurses, dentists, chiropractors and other licensed health professionals escape charges of practicing medicine without a license because they have an exemption to the overly broad statute. But there is no such protection for the unlicensed alternative health care practitioner; they can be charged with practice of medicine whenever a complaint gets the medical board's attention. The fallout of this legal vulnerability is far-ranging: it includes a fear of becoming too prominent, a fear of being too commercially successful, a fear of being the innovator and a fear of being seen as outspoken in criticizing the more commonly used methods of treatment. As a result of the fear and intimidation, consumers can tend to be deprived of the benefits of the most honest discussions that they could have with their practitioners, and of the most innovative treatment methods. The practitioners themselves may be forced into early retirement or they and their treatment option could be difficult to find.

Licensure and Turf Battles

If the state of Minnesota deems it desirable to regulate an occupation, it is state policy to only regulate the occupation with the least restrictive manner and only when an occupation would pose an imminent risk of harm to the public. In view of that, legislative health committees have declined to allow licensure for currently unlicensed modalities such as naturopathy to go forward. A registration bill for massage therapists has also been tabled. Licensure and registration approaches have other drawbacks; they seem to set up battle lines among practitioners, between those that would be allowed to practice under the proposed licensure and those that would be excluded. Minnesota's new approach to affirming health freedom avoids stirring up those kind of turf battles.

Minnesota's Freedom Solution

To assure consumer access to as many practitioners as possible, the state of Minnesota has set up a new office to provide government oversight to unlicensed practitioners. In turn, the practitioners practicing under the new statute will be exempt from criminal charges of practice of medicine without a license. The office will oversee those who are practicing "the broad domain of complementary and alternative healing methods and treatments." Naturopathy,

homeopathy and herbalism are just a few of the therapies listed in the statute as examples of practices that the new chapter of law deals with. A set of 24 rules of ethical conduct is given for the new office to oversee. The office will receive consumer complaints, investigate them, and enforce the ethical rules. The ethical rules include prohibitions against fraud, false or misleading advertising, sexual contact with a client, and inability to practice "with reasonable safety ... to the client." The rules of conduct are clearly not intended to allow suppression of therapies on the grounds that they are new or different from conventional practice. "The fact that a ...practice may be a less customary approach to health care shall not constitute the basis of a disciplinary action per se," the new law states. The new law takes effect July 1, 2000.

How They Did It

A statewide grassroots lobbying effort by the reform project helped move the health freedom bill through the tougher committee battles. A core of about eight leaders met one night a week for three years to drive the effort forward. Serving as the reform project's legal consultant was Diane Miller who, supported by a volunteer legal team, formulated the freedom approach behind the bill. Miller, along with citizen-turned-lobbyist Jerri Johnson, a local homeopath, led the lobbying work at the capitol. and helped to navigate the bill through 15 committees.

Consumers in all parts of the state - outstate as well as metro - played a role in reaching their elected officials. They gathered with their legislators in their districts to share their stories of the personal importance of alternative care options and to demand active reform. After a while, it was obvious that, for the people of Minnesota, this reform bill had very broad support.

The chief author in the house was state Representative Lynda Boudreau, a Republican. Her leadership in moving the bill through key house policy committees was crucial. She was able to work with supportive colleagues to survive intense amendment discussions and formulate a bill that would meet new-found broad support.

Then it was largely the senate's turn, with the committee deadline clock ticking. State Senator Twyla Ring, a Democrat and a rookie in the senate, was the senate author who piloted the senate version through three major dramatic hearings in one week. Senator Ring agreed to take up the senate authorship after the death of a previous senate author, Senator Janet Johnson, last August. Elected in a special election to fill the vacancy left by Johnson's death, Sen. Ring, had been a personal friend of Johnson's. Sen. Ring became strongly committed to helping finish the senate journey for health freedom that her friend Janet had begun. She did, with the help of many of her senate colleagues.

After going through a conference committee, final passage in both houses was by strong margins. On May 1st, the House approved the bill by 110 to 23, following a final, lively debate. The final senate approval for the bill on May 4th was by a 58 to 1. The freedom train had arrived.

Governor Ventura's policy advisors supported the health freedom bill, and the governor's office was deluged with calls from citizens urging that he sign the bill. Without fanfare, Ventura signed the bill May 11th in the privacy of his office.

Contacts:
Leo Cashman, organizer 612 721-3305
Diane Miller, legal consultant & lobbyist c/o 612 721-3305
Jerri Johnson, homeopath, lobbyist 651 688-6515
Rep. Lynda Boudreau, chief house author 651 296-8237
Sen. Twyla Ring, chief senate author 651 296-5419
Nancy Hone, local homeopath 651 647-9908
Marillyn Beyer, health educator 612 926-5456

Top of this page

Home

Alternative Medicine What's HOT

6/26/00

Bringing Healthcare Freedom to the States

Bringing consumers freedom of access to Complementary and Alternative Medicine (CAM) modalities and, at the other end of the stethoscope, enabling physicians and other health care practitioners to legally provide CAM treatments are two goals of the Health Freedom movement, sometimes called the Medical Freedom movement. As of summer 2000, citizens, lobbyists and legislators in more than a dozen states have proposed or are pursuing Health Freedom legislation. Several states have already passed such precedent-setting bills.

"Health freedom fighters" in Minnesota are celebrating the most recent victory: The Complementary and Alternative Health Care Freedom of Access Act, now known as Statute 146A, was signed into law in May 2000 by Governor Jesse Ventura. Joining in the celebration are members of the Minnesota Natural Health Legal Reform Project, the nonprofit group that inspired the legislation, and the two state legislators who authored it, Senator Twyla Ring (Dem.) and Representative Lynda Boudreau (Rep.). Under the new statute, which will take effect in July 2001, Minnesota practitioners who practice unlicensed complementary and alternative modalities -- that is, who practice modalities not outside the limits set forth within the law, such as dispensing controlled substances -- will not be charged with practicing medicine without a license.

As Healthlobby.com/news explains, Minnesota's "unlicensed complementary health care practitioners now enjoy freedom of practice and are brought into the circle of professional accountability. . . . [The MN Department of Health's] "Complementary Medicine, A Report to the Legislature" is the most original and comprehensive report yet published by a state agency. It provides a fair and even overview of the use of CAM in the state, and extrapolates socio-economic data to apply to Minnesota populations."

Groundbreaking Health Freedom Fights

Two states currently fighting for health freedom are New York and California. In New York, bills introduced to define the term "medical necessity" have passed all committees and, as of June 2000, await floor votes in both houses. The introduction of these Medical Necessity Bills was brought about by FAIM, The Foundation for the Advancement of Innovative Medicine.

FAIM spokesperson Monica Miller explains why this legislation is needed: "You go to your doctor because you have a concern. Your doctor tells you that yes, you were right to be

concerned, and together you work out a treatment plan. But now, your insurer is telling you that your concern is NOT a medical necessity, and that the treatment plan is NOT medically necessary care! . . . How is it that your doctor is no longer the best judge of your medical need? How is it that you lost your voice as well?

"NY Public Health Law and Insurance Law permit insurers and HMOs to define the terms 'medical necessity' and 'medically necessary care' for themselves. And, most insurance contracts reserve for insurers or HMOs all control over how the terms of their contracts are interpreted and applied. In other words, everything is set up so that it is presumed that the insurer determines your medical necessity because it is a term of contract, not a term of law."

In California, a Medical Freedom Bill to authorize alternative treatment for cancer, called the "Physicians' Right to Practice," has passed the Senate and is scheduled for an assembly Health Committee hearing on June 27. The organization California Citizens for Health Freedom note that more than five years of effort by their volunteers have gone into preparing for this bill. If passed, it will lift the California code restriction barring cancer treatments other than chemotherapy, radiation and surgery, allowing citizens to select alternative cancer treatments that are currently available to citizens of other states.

You Can Help "Soften the Ground"

Citizen involvement can make the difference in not only passing but also prompting introduction of Health Freedom Bills. Leo Cashman, co-founder of the MN Natural Health Legal Reform Project, wrote: "The fact that citizens built a large and growing movement demanding freedom of access to safe, alternative healthcare should change the atmosphere in all the health licensing boards; the people spoke, the legislature listened, and the governor signed. The political breakthrough also 'softens the ground' for the whole idea of natural healing's significance. Quality healthcare need not always be risky and invasive. Non-surgical, non-drug treatment methods have an important place in the healthcare marketplace."

To learn which states have passed Health Freedom Bills, or to keep up with what's happening with state Health Freedom legislation, visit www.healthlobby.com.

To find about the Foundation for the Advancement of Innovative Medicine (FAIM), go to www.faim.org.

To learn more about the Minnesota legislation, visit www.minnesotanaturalhealth.org.

For California updates, go to www.citizenshealth.org.

To find out what's happening on the national level, go to the link "Track Important Legislation" at www.citizens.org.

To read the full text of the article by Leo Cashman, co-founder of the MN Natural Health Legal Reform Project, go to Twin Cities Wellness site at www.tcwellness.com.

Minnesota: the quackiest state in the nation?

Yes folks, its true. Minnesota is about to become the "quackiest" state in the nation with less consumer health care protection than any other state. According to Dr. John Renner, president of the National Council for Reliable Health Information, Minnesota will have lower standards than many countries including Malaysia and Uganda.

The impetus is the Complementary and Alternative Health Care Freedom of Access Act which covers "the broad domain of complementary and alternative healing methods and treatments, including but not limited to:(1) acupressure; (2) anthroposophy; (3) aroma therapy; (4) ayurveda; (5) cranial sacral therapy; (6) culturally traditional healing practices; (7) detoxification practices and therapies; (8) energetic healing; (9) polarity therapy; (10) folk practices; (11) healing practices food, food supplements, nutrients, and the physical forces heat, cold, water, touch, and light; (12) Gerson therapy and colostrum therapy; (13) healing touch; (14) herbology or herbalism; (15) homeopathy; (16) iridology; (17) body work, massage, and massage therapy; (18) meditation; (19) mind-body healing practices; (20) naturopathy; (21) noninvasive instrumentalities; and (22) traditional Oriental practices, such Qi Gong energy healing." Incredible as it seems, the State of Minnesota is about to officially recognize and legalize these practices!

And the alternative practitioners are about to walk away from the hearing tables of St. Paul with a very sweet deal. They won't even have to pay licensing fees.

It seems odd that Minnesota licenses kick boxers, blackjack dealers, apprentice barbers and manicurists as well as coaches, contractors, health care professionals and teachers and yet, twenty-two categories of health care practitioners are being exempted from licensing by passage of this Act. Protections in this Act will **only** cover those practitioners who are "**not** licensed or registered by a health-related licensing board or the commissioner of health, or does not hold oneself out to the public as licensed or registered by a health-related licensing board or the commissioner of health when engaging in complementary and alternative health care practices."

In the absence of licensing the savvy consumer might ask, How will the state tell the difference between a bona fide iridologist and a quack iridologist? Well, that's a moot point. Under the rulemaking which is to follow, "the commissioner may not adopt rules that restrict or prohibit persons from engaging in complementary and alternative health care practices on the basis of education, training, experience, or supervision." It appears that any person with any sort of alternative medicine practice or treatment has been judged worthy of the consumers' dollars.

So its 'Quacks welcome!' No training or education required – not even a jr. high health class. Minnesota, hats off to thee, again on the cutting edge! Robert Leach, executive director of the Board of Medical Practice has suggested the Act will bring back quackery not seen in a hundred years.

The Minnesota Department of Health took no stand on this bill. An agency spokeswoman told us there was no MDH opposition because "they do it anyway." We appreciated her frankness. We always wondered what an anarchy would look like. Perhaps, this is a glimpse.

It used to be that we in Lake Wobegone were on the cutting edge of consumer protection but its hard to make that claim with this Act. Yes, there are provisions for sanctioning the uneducated, untrained, unsupervised and unlicensed health practitioners. These sanctions may go so far as to result in suspension or revocation of the un-license. The alternative providers aren't supposed to have sex with patients or to be under the influence while "healing." But as to the methods they use, the alternative practitioners are insulated for the Act provides "The fact that a complementary and alternative health care practice may be a less customary approach to health care shall not constitute the basis of a disciplinary action per se."

Lobbyist Leo Cashman wrote "Clients would assume the risk of their decisions after being given adequate disclosure of information regarding the practitioner's qualifications, the nature and benefits of the healing modality and common associated risks." We couldn't find the part about disclosure of modality benefits in the Act itself but we think Mr. Cashman is correct in stating consumers will assume risk.

The Act does not require the untrained health practitioners to carry liability or malpractice insurance. Theoretically, consumers retain the right to seek redress in court – a right the Legislature cannot remove. But this right isn't worth much if there's no money to be had.

There's a presumption in all this that the future unlicensed health care practitioners will be sincere educated people who truly believe in their modalities of alternative medicine. Their patients will be financially comfortable, generally healthy, educated health connoisseurs willing to have fun with untested theories which are largely benign when applied to a healthy population. Among affluent baby boomers, there is a certain cachet in being a devotee of an off-the-wall practice. It's a status symbol: one has the time and the money. That there will be greed and exploition of the insecure, the elderly, the poor, the chronically ill, the dying, and the lesser-educated - the groups commonly targeted by quacks - seems not to have entered the legislative picture.

We know better for we've spent over a decade on staff at the Museum of Questionable Medical Devices. Here's how gadget quackery works:

Under this Act, we can spend $400 and manufacture two thousand little pieces of rubber with nubs, call it acupressure to assist weight loss, and gross about $8,000 in sales. Since we don't want to actually sell, we'll split it 50-50 with our "practitioners," probably a bunch of women who will sell the gizmos to their buddies at work. Then, we will repackage a couple thousand gas grill igniters and market them to seniors as an arthritis cure at $88 each. The gross profit would be $170,000. Again, we can easily spend half on sales.

We could make up a little gift box with a book which claims sharks don't get cancer and a bottle of 300 shark cartilage tablets (which don't even have to be shark cartilage - a calcium tablet is a calcium tablet after all - and who will inspect the pills anyway?). The gift set will retail for about $129.00. Of course, we would never claim that shark cartilage cures cancer - - we would just give out copies of testimonials. The perfect product for the recently diagnosed cancer patient!

With a capital investment of well under $5,000 and a willingness to pay a 50% commission, we could net over $90,000 the first year without ever seeing a "client." This will all soon be legal in Minnesota - this business of clients assuming the risk.

It won't matter that we know these products don't work - they are alternative and clearly fit into the categories delineated in the Minnesota law. Besides, with the placebo effect, there are sure to be some positive results with our products. Nothing in the Act requires the "practitioners" to believe in alternative medicine. Indeed, in the history of U.S. quackery, those motivated by profit fared far better financially than did the hands-on practitioners and patients who bought their goods. It will be legal. That's all that matters.

It seems unlikely that this bad legislation can be stopped at this late date. The Complementary and Alternative Health Care Freedom of Access Act has passed both the Minnesota House (HF0537) as part of an omnibus bill and Senate (SF0689) - but not as part of the Senate omnibus bill. The two versions differ slightly. The Act may be considered in a conference committee headed by Sen. Don Samuelson and Rep. Kevin Goodno. The remainder of the Committee, expected to meet during the week of March 27th, has yet to be chosen. If the Alternative Medical bill is not considered by the omnibus bills conference committee, it will again be up for a vote in the Minnesota House of Representatives.

If the Act passes, as expected, it will be sent to Governor Jesse Ventura who, according to his office, will make up his mind about the Act when he receives it. Governor, we would be honored to show you a few of the "noninvasive instrumentalities" this Act will authorize before you consider signing the bill into law. Your place or our museum, any time is fine.

Bob McCoy
Curator

Shawne FitzGerald
Associate Curator

http://www.mtn.org/quack/
The Museum of Questionable Medical Devices
201 SE Main Street
Minneapolis, MN 55414
612-545-1113
Mar 23 2000

HOME | VISITOR INFO | INDEX | DEVICES | WHAT'S NEW | QUACKS | EPHEMERA | GIFT SHOP | LINKS|

Rep Boudreau

The role of government in healthcare is to protect citizens from harm, and at the same time protect citizen rights to individual choice and autonomy.

Citizens have basic rights to make personal choices regarding their own health and well being and the constitutional right to access any health care practitioner, treatment or information source that they desire. This right remains whether or not treatment options are generally accepted, well known, recognized, or researched and regardless of a practitioner's education, training and experience.

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

The existing Mn Statute 147.081 has an overly broad definition of the practice of medicine which reads "anyone who offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person" is practicing medicine without a license, and is guilty of a crime.

Tools that helped to guide us included:

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

A 1998 study conducted by the Minnesota Department of Health, directed by the legislature in 1997, which provided recommendations regarding Complementary and Alternative therapies. That study covered the types of therapies available in the state, the existing regulation of such, utilization, and possible regulation concepts.

A 1999 program evaluation by the Office of the Legislative Auditor which affirmed that the Chapter 214 standards should be applied more consistently before new regulation is to be enacted. "The fundamental requirement is to demonstrate that there is a significant threat to public health or safety from unregulated practice. The burden of proof is on the proponents to make the case that occupational regulation is needed and that the proposed regulation meets specific statutory criteria. Mn law requires the least restrictive form of regulation to be used if regulation is

necessary."

The Minnesota Complementary and Alternative Health Care Freedom of Access Act of 2000 passed last year and in the House and Senate and was signed by Governor Ventura. It will become law in July of this year. This did not happen without extensive debate, vehement opposition from many representing traditional medical interests, and persistent support from consumer advocates. Because the chair of Civil Law, Representative Steve Smith allowed well over 10 hours of committee time on this legislation, the bill was able to progress in design and support due to many changes. Not everyone was on board after passing through nine committees in the House and Senate, but the Board of Medical practice not longer opposed the bill.

The Freedom of Access Act created a new office in the MDH to provide government oversight of the practices of unlicensed complementary and alternative health care practitioners which will handle consumer complaints and enforce practitioner prohibited conduct.

The legislation protects consumer options while providing strong consumer protection by:

* Assuring that all consumers receive notices and client bill of rights,

*Providing guidelines for practitioners by listing grounds for disciplinary actions and setting out what to include in the client bill of rights,

*Mandating that the Dept of Health report back to the Legislature within two year with information on the number and nature of complaints under the new office.

This bill creates good public policy by recognizing that there is a broad range of unlicensed healing systems and services that play an integral role in our community, and that by providing government oversight in these relationships between consumer and practitioners, the role of government is fulfilled.

In Summary:

I. State and federal governments must be vigilant during health care reform to preserve the balance between government regulation and an individual's right of self determination and right of choice.

II. Existing regulatory health care statutes should be reviewed and revised to acknowledge and promote the use of the broad domain of healing arts and trades in a nonexclusive manner by all consumers and by all professions both licensed and unlicensed, thus creating the widest range of choices for consumers.

III. A regulatory framework should be utilized that embodies the least restrictive means of regulation, and that provides an informed consumer environment and a system for consumer recourse in the event of a complaint. For state regulation, The Minnesota Complementary and Alternative Health Care Freedom of Access Act of 2000 can be referred to for conceptual planning. For federal legislation, bills amending the definition of the word drug can be reviewed for conceptual planning.

IV. Government should look to the future and create laws that allow for the greatest amount of innovations and that ensure freedom of consumer access to all health care options.

Bruce Nordstrom (13)

Statement
Of the
American Chiropractic Association
Before the
White House Commission on Complementary
And Alternative Medicine Policy
March 2001

On behalf of the American Chiropractic Association (ACA), I am honored to provide the commission with policy recommendations as they relate to the issue of wellness. As I stated in a previous presentation before the commission, the key principle behind chiropractic care as well as many other complementary and alternative therapies is wellness. I urge the commission to ensure that the promotion of wellness is paramount in any recommendations provided to Congress.

It is my understanding that the commission, in its initial draft recommendations, is considering the development of a consumer-oriented alternative medicine division within the Department of Health and Human Services (HHS). This department, among other things, would coordinate the dissemination of information on CAM. Such a department would be helpful in ensuring that accurate CAM information is provided to not only the general public but also within HHS itself. As HHS moves forward on various health care initiatives, such a resource would be extremely beneficial in promoting CAM within the department.

In addition to these activities the ACA would like to suggest additional activities for this proposed division.

- The Commission should recommend that Congress provide adequate funding for such a division, and should also earmark a specific amount to launch a wellness campaign to inform consumers about their health care options. With input from various CAM organizations, a well-developed wellness campaign could greatly enhance public awareness on the effectiveness of various CAM procedures as well as provide consumers with greater health care options. In the era of increased consumer access to health care information – via the Internet and other vehicles – there are many conflicting reports on the efficacy of many CAM procedures. A federally funded wellness campaign could address these misleading reports. However, care must be taken in promoting any CAM/tradition modality, it must be based on sound clinical evidence.

- Such a wellness campaign could have many facets, including, but not limited to, targeting the insurance industry, workplaces and also basic education at the elementary-school level. For example:

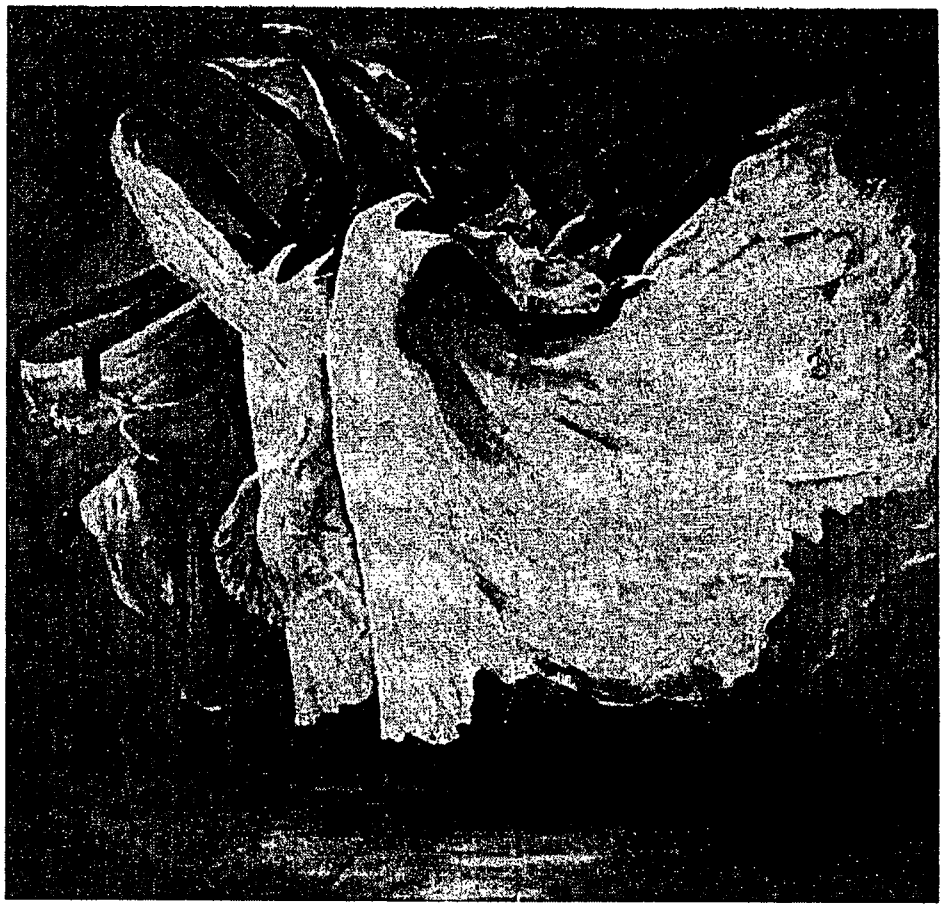
    - Workplace – Each year approximately 13.2 million workers sustain nonfatal injuries, such as low-back pain and fracture, according to the Bureau of Labor Statistics and 862,000 suffer from work-related illness at

a cost of $171 billion. In many cases, employers have resisted the concept of ergonomics and safety standards. However, they may not realize the benefits they will attain from improved workstations and safety. A wellness campaign that targets the workforce could focus on the statistics that show that although safety/wellness comes at a cost, a more user-friendly work environment reduces risk and fatigue. Therefore, it not only decreases overall costs, it also protects their most valuable resource – their employees.

- Insurance – As health care costs continue to rise, payors need to better understand the effectiveness of wellness in containing health care costs. Payors should be encouraged to offer preventative alternative therapies as paid insurance benefits rather than a patient-paid responsibility. Current coverage constraints restrict a patient's ability to seek the treatment they need to stay healthy and to promote their well-being. The insurance industry could be targeted with the message that wellness works. This insurance-specific wellness campaign might even provide examples of other payors who are seeing the real cost benefits associated with wellness. Once payers and their policy makers see the bottom-line cost savings realized by those who embrace a wellness concept, one would hope that they would provide early and regular wellness interventions to those they insure.

- Elementary schools campaign – If consumers are to embrace the concept of wellness, it must start with the children. In elementary school, children begin to learn the basics of health care – healthy nutrition, physical education, and a general concept of wellness. In the context of basic health care, a wellness campaign could be targeted to ensuring that students be introduced to the whole spectrum of health care professions, including, among others, chiropractic, acupuncture, nutrition and massage. In addition, the concept of wellness should be embraced in other areas of learning, including, but not limited to, computer based-classes. Generally computer equipment is not designed for young, growing bodies. Children should be taught to sit properly at computers, stretch when appropriate, and focus away from the computer to avoid eye strain. Educating the consumers of tomorrow on the benefits of wellness and providing them with valuable information they can learn and grow from is essential in any wellness campaign.

The ACA encourages the commission to consider the concept of a national wellness campaign to encourage and facilitate the use of CAM as a viable health care option. Thank you for allowing me the opportunity to testify, I will be glad to answer any questions you may have.



Honoring Our Uniqueness

White House Commission
Complementary and Alternative Medicine

March 27th, 2001
Marcellus Walker MD
African American Health Foundation

Health Education And Research For The African Diaspora

I am Marcellus Walker MD, a practicing board certified internist, trained in multiple forms of CAM therapies over the past 10 years. I am author of the book Natural Health for African Americans, and founder of the website africanamericanhealth.com. I was a panel member for the NIH consensus conference statement on Acupuncture in 1997, and am founder of the recently formed African American Health Foundation. This foundation is dedicated to the dissemination of best practice information in conventional and CAM practices. It also is dedicated to direct research endeavors to resolve the existing healthcare crisis in the Africa American Community.
Since this time is devoted to issues of information, and will not support comment on issues of research in CAM, I will restrict my exchange to the following areas;

1. To alert you to specific subpopulation needs and issues of the African American community for successful outcomes.
2. Outline suggested requirement for information dissemination (Issues of information digestibility).
3. Expand our perception of space that healthcare and CAM therapies occupy.
4. Share my observations that may be helpful to the commission.
5. Suggested ways that can provide incentives for website who provide quality information to their audiences.

SPECIAL NEEDS

There is a healthcare crisis in the African American community, with conditions like HIV, addiction, heart disease, diabetes, cancers, lupus, and mental health issues being disproportionately higher in this population. Conditions like hepatitis C, and prostate cancer are examples of conditions that are more resistant to treatment compared to other groups and mandating exploration into new areas for solutions. Both these factors speak to the need for focused research, education and improved health delivery to this under represented population.

Compounding this, there has been a long history of distrust in the medical community, and a natural tendency to favor CAM approaches to healthcare issues. CAM is viewed as empowering, and feels right. Further CAM supports the black health heritage tradition, as has been seen in many if not most minority communities. There is a tremendous need for the support of agencies that will provide information to the over 40 million, who can be clearly classified as a special needs health group.
Based on my years of training and experience in both conventional as well as multiple complementary medical practices, I am personally convinced that a multidisciplinary integrated medical approach is the solution to this health crisis.

REQUIREMENTS FOR INFORMATION

In order to deliver this information responsibly, the first principle we may want to consider is that information is food. As on the physical level, "we are what we eat". This is also the case with information. Bad or partial information can leads to bad outcomes, along with time and resource wasting, neither of which we can afford. Yet our thirst and hunger for information is the driving force for the Internet, and other forms of rapid

information assimilation. Therefore there is no time to sit still, and we are asked to move into action.

Here we must understand that there is a difference in our ability to digest this information. For most Americans, including African Americans, because of its complexity, this information needs to be presented as "high-powered baby food". This means it is easy to understand, and brief. This can be expanded into more detail if wanted or required. Also there should be appropriate informed consent before digestion. I would recommend that this is presented in the form of a rating scale that allow consumers the ability to decide if the information is something they choose to digest and assimilate. This approach will allow a lot of information to be presented to serve a wide array of needs and reasons for searching, while honoring time, and providing appropriate cautions and guidance.

PERCEPTION OF SPACE

The next issue is space definition. One of the reasons in my opinion that we are having some difficulty in a consensus of whether to call these therapies CAM, Integrated medicine, or something else, is that they are all umbrella terms. If we look on a deeper level, all approaches may be categorize by the systems that they affect.
There are two systems that simultaneously exist.

1. Those that treat the **physical system**. These include conventional and CAM approaches.
2. Those that treat our **energy system**. These classically are CAM therapies.

CAM therefore actually falls into both groups, really complicates the task of classification. Because we have two systems, we need to consider developing a quality rating scale that takes this into consideration. We have always known that medicine is a science and an art. Our physical systems can be studied by conventional research approaches, while some physical directed therapies and most energy systems therapies are still "art form like" in our research of them.

Since the science of medicine only occupies a limited space of our overall experience, this does not fill the appetite and needs the American population. Time and the consumer needs do not allow us to do nothing with that which we still have not proven. Therefore information that is still an art form needs to be presented in a rational and best practice responsible way.

RECOMMENDATIONS

I suggest that information be presented in a dual 5-point rating scale for both the science and the art of medicine. This dual rating scale will allow CAM therapies to fit nicely into their appropriate categories, and will allow the consumer to consume with more complete disclosure and responsibility for what they choose to digest.
Factors that need to be included in the art side of the rating scale have been listed in the attached spreadsheet. This scale is intended to tease out issues of practice experience, since those practices that can best elucidated what space they are working in, have a deeper understanding of their art. When one can elucidate what space they are working

in, and the what system the therapy is working on, they have a clearer understanding of the cause and effect relationship of their work, and therefore can make this understood to the consumer. This information therefore has more objective weight and should be rated so. This puts the responsibility of information sharing back on the person preparing the information prior to consumer digestion.

CONCLUSIONS

1) Development of a dual rating scale that honors science and best practice approaches. This rating scale will allow addressing issues of unique population needs, and support clarity regarding what system is being influenced.
2) Funding of private information sites that follow government outlines for information presentation.
    a. Sites have advisory board
    b. Sites allow quality assurance oversight by regulatory agencies that may be established for such purposes.

I have attached to my testimony an example to the rating scale.

MAr. _LUS WALKER MD
AFRICAN AMERICAN HEALTH FOUNDATION

RATING SCALES FOR THE EVALUATION OF BEST PRACTICE APPROACHES IN MEDICINE										
SCIENCE										
SCALE RATING	RANDOMIZATION	CONTROL	SELECTION CRITERION	PROSPECTIVE	DROP OUT	POWER	METANALYSIS			
5	X	X	X	X	X	X	X			
4	X	X	X	X	X	X				
3	X	X	X	X	X					
2	X	X								
1										

MA . _LUS WALKER
AFRICAN AMERICAN HEALTH FOUNDATION

RATING SCALE FOR BEST PRACTICE APPROACHES TO MEDICINE

ART OF MEDICINE

POWER IN ART OF MEDICINE

SCALE RATING	EFFECTS SEEN ARE WORKING IN THE PHYSICAL SYSTEM, ENERGETIC SYSTEM, OR BOTH	WHAT SPACE WITH IN THAT SYSTEM IS THE ARTICLE ADDRESSING	SIDE EFFECTS	SELECTION CRITERIONS	DOSING	DROP OUT	SUBGROUPS	CONTROL GROUPS	RANDOMIZATION	OUTCOME
5	X	X	X	X	X	X	X	X	X	X
4	X	X	X	X	X	X	X	X		X
3	X	X	X							X
2	X	X								X
1										X

THE SPACE THAT AN ARTICLE IS WORKING IN NEEDS TO DEFINE WHERE THE THERAPY IS ATTEMPTING TO EXERT INFLUENCE. ENERGETIC, PHYSICAL

SELECTION CRITERION- WHAT SPECIFIC GROUP IS THIS THERAPY DIRECTED TO AND KEYS TO INCLUSION

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Chambers

Divider Title: _____

March 27, 2001

Submitted to:

White House Commission on Complementary and Alternative Medicine Policy
c/o Department of Health and Human Services,
Washington, DC

Comments on the language of healing

By **Friends of Health**
Diana Chambers, President

friends of health
fostering the art and science of integrative medicine

2014 Kalorama Road NW Suite 3
Washington DC 20009
Phone 202.483.3080
Fax 202.483.7369
Email foh@friendsofhealth.org

What we call the beginning is often the end.
And to make an end is to make a beginning.
The end is where we start from.
T.S. Eliot

Given yesterday's focus on CAM in the media, I would like to focus my comments – as I did when I testified in front of the Commission last year – on the language of healing.

I am concerned, as I believe are many of the Commissioners, with the language forms that are used in the discussions here, as I have heard numerous references to the inadequacy of the language, with some frustration that nothing better is available. We live in a post-modern society. Post-modernism operates on the assumption that rhetoric is not descriptive of what is but is generative of what is. It does not point to something that is there anyway, but in the moment of utterance creates something that did not exist until the moment of utterance. When something is said, the world is changed. Language leads reality.

Whatever language the Commission uses in dialogue and in its final report will be highly influential in the ways in which the practices with which we are concerned are subsequently described. I would like to challenge the Commission and its staff to take the embracing of accurate language as of central significance, to help shape the reality in which the practices with which we are concerned must operate, as opposed to living with the language that has been given to this point. When I testified last year, one of the suggestions from the Commission was that we might seek a grant from the National Endowment for the Humanities to explore the language question. My plea is that you do not wait to make such a recommendation in your final report but that you work with the language issue NOW.

All language systems only make sense if we are willing to accept them. The implication of the use of the words *Complementary and Alternative Medicine* and, worse yet, the acronym *CAM*, is that we have given scientific and allopathic language a privileged place

in describing healing. While CAM has become the accepted phrase in many circles, such language should not be allowed to dominate our dialogue, as it is not universal language, which is especially obvious when global approaches to healing are considered.

So the question concerns what narrative we have to match the hard, fixed narrative of Western medicine – with its focus on fighting, disease and cure. The alternative has to be elusive, or else we become as hard and fixed as the narrative of allopathic medicine. I recognize that the problem with an elusive narrative is that it sounds as if we don't know anything in front of hard-nosed fact and reality. In my opinion, a more elusive narrative allows us to maintain our ethos and essence, and opens space for continued dialogue. This is surely part of the wisdom of thousands of years of Chinese strategy on the matter, with the Tao Te Ching giving many such references, e.g. "This is called a Subtle Insight. The yielding can triumph over the inflexible; the weak can triumph over the strong." (from passage #36) and "Existence and nonexistence produce each other. Difficulty and ease complete each other. Long and short contrast each other. High and low attract each other. Pitch and tone harmonize each other. Future and past follow each other." (from passage #2)

Poetry, as one option for us, pushes the envelope to find language that matches the unusual contours of our situation. Metaphor, drama, poetry and imagination effectively challenge certitude, and are vehicles for possibility. If anyone here saw the wonderful HBO production "Wit" on Saturday night, this contrast was brilliantly played out in the use of the metaphysical poetry of John Donne in the context of a woman's dying in a hospital bed. There was a reflection on Donne's sonnet on death:

Death be not proud, though some have called thee
Mighty and dreadful, for, thou art not soe,
For, those, whom thou think'st, thou dost overthrow,
Die not, poore death, nor yet canst thou kill mee;

The reflection in the play hinged on the use of a comma or a semicolon, in translation in this passage, with the recognition that a semicolon separated life from death in a way in which the poet did not intend. A comma allowed for a lighter veil between the two.

Using this poem as an example, we might ask ourselves why the clinical outcome of death has to be seen as the defining feature when addressing health. Yet our discussions almost inevitably move in the direction of saying death must be avoided at all costs.

We need to find ways in the language we use to allow not for lack of certitude but for possibility and life. The language of technical medicine, implicit in the term CAM, is so inherently lifeless, and yet we're gathered here in this room today to talk about healing and life. I urge the Commission to stand back and take a look to see if the language you're using is consistent with your real concerns and interests.

Thank you.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Miller

Divider Title: _____

Robert D. Miller
The First Church of Christ, Scientist

NOTES:
Public access to information about prayer as a whole system of self care is important. Prayer is a stand alone system that may include healing practitioners. Non-medical nursing assistance is available. Some may approach this system as complementary, while determining what is best for their needs. Assuring reliable authoritative information would be critical to any patient seeking the most appropriate means of advancing their health prospects.

Kathleen Mary Quain CSW
Foundation For Health & The Environment

5

The First Church of Christ, Scientist in Boston Massachusetts

Washington, D.C. Office
Committee on Publication

Comment before the
White House Commission on CAM Policy (WHCCAMP)
March 27, 2001 - Washington, D.C.

My name is Robert Miller, Manager, Federal Office, Christian Science Committee on Publication, and I appreciate this opportunity to speak before the Commission. You've heard a great deal of testimony over the last year or so, and some of that testimony has been about healthcare practices that center on spirituality.

The term "spirituality" is used quite broadly today -- it means many different things to many different people. Yet even with this widespread application of the term, one important element of spirituality is often overlooked. And that's prayer.

That's why I wanted to be here today. As the Commission looks at various spiritual practices, prayer-based healing needs to be represented. This method of healing is one of the most popular alternative remedies in the country. A recent survey indicates 44% of the general public have used prayer as an alternative treatment.[1] And according to George Gallup, Jr., 41% of Americans surveyed reported having experienced physical or mental healing as a result of prayer.[2]

Prayer is certainly diverse and multi-faceted. It is recognized in many cultures as contributing to positive health outcomes. These health outcomes have stimulated research into spirituality in the fields of medicine and psychology. And I believe this research is moving us toward an expanded understanding of health in general, and self-care in particular.

It's certain that some elements of religious practice may appropriately be considered adjuncts to medical practice and behavioral medicine. However, this does not mean that prayer-based healing should be governed and regulated within a medical model. And, although there is obvious correlation between "mind/body medicine" and "prayer-based healing" (such as the importance of the thought of the patient), these terms are not synonymous.

---

[1] "Quackery No More," *American Demographics*, January 2001, pages 10-11

[2] Video interview with George Gallup, Jr.: "...41% of the American people have had a remarkable healing experience either related to a physical problem or related to an emotional or psychological problem."

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Quain

Divider Title: _____

White House Commission on Complementary and Alternative Medicine Policy
March 27, 2001

Testimony provided by Kathleen Quain, CSW: President, Foundation For Health & The Environment

The extraordinary work outlined in Daniel Tobin, MD's book, "Peaceful Dying" is being implemented into mainstream healthcare and could easily integrate with complementary medicine. Dr. Tobin's program is holistic, wide ranging in terms of scope and provides an opportunity in over 50 demonstration sites in national models with HMO's and multiple providers to use the advanced illness coordinated care model. Dr. Tobin is eager to integrate and collaborate complementary medical strength into the evolving model.

The organization and dissemination of wellness reflects a new medical school curriculum that is practical, easy to access and understand, and focuses on creating national as well as individual well-being. Through information technology and with a wellness-centered emphasis, CAM educates people on how to reduce stress, fear and levels of hate, highlighting the importance of breathing, laughter and joy.

Most diseases can be prevented if people understand how to create health. Every day our bodies need nutrients, including vitamins and minerals. Obesity is a sign of the body being undernourished. If people ate food that was meant for our anatomy and physiology, many diseases would be eliminated. In other countries it is hard to find a case of Alzheimer's. Neuropeptides require nourishment. When the body's "nourishment" is depleted, the brain also does not have proper nourishment.

Globalization has made the US more vulnerable to exotic diseases. CAM bolsters worldwide medical practices and helps solve some of the medical problems that the US is facing.

Here are some suggestions for organizing CAM information:

- **List the diseases that American's suffer from.**
- **Offer the public successful interventive information for each disease, starting with the least aggressive intervention, to the most aggressive allopathic treatment.**
- **Do a preventive seasonal program based on Elson Hass, MD's work, "Staying Healthy With The Seasons."**
- **Strengthen the immune system through detoxification, imagery, peaceful relaxation, art therapy techniques and the use of pressure points for the immune system.**
- **Emphasize prevention by clearing out poisons before they make people ill.**
- **Offer our nation's most effective programs that combine science and faith, art and technology.**

Nationally, there are unprecedented "cluster" areas of autistic children in America. There appears to be evidence to show that considerable heavy metal content is present in the blood of an autistic child. Heavy metals can be non-toxically removed by using nutritional supplements that bond with the heavy metals and detoxify the pollutants from the child's body. Many parents coping with autism in their child do not know the most progressive treatments for their child's condition. Autism can significantly improve with the correct complementary medical care. Through CAM parents could access crucial health information for autistic children on the internet.

The escalation of violence in America's childhood population starts with neurotoxicity. Neurotoxicity in a child's body is caused by pesticides, heavy metals, food additives, and other environmental pollutants. Nutritional detoxification programs can be offered on the internet for parents and children. Through the media, visual programming that supports healing can be directed toward America's childhood population.

CAM helps American children by strengthening them from within, restoring values that have eroded and installing love through programming. To feel their aliveness, children look for constant stimulation. Historically, children have been stimulated with sports and personal attention. Physiologically: heavy metals, especially lead, bond with the body's receptors for dopamine. Dopamine is necessary to give a person a sense of pleasure – so many American children with heavy metal content are never satisfied and physiologically get bored. One way to get physiological stimulation is to get shocked, excited, stimulated with soda's, drugs, chocolate, sugar, video games – this stimulates the adrenals to release norepinephrine, which activates the fight or flight response. As a result, many children feel the need to create anything that shocks or scares them. The media and toy manufacturers do market surveys on what kids want and what will sell, which translates into violence on TV, in movies and in video games. Children's television is paced in nine-minute segments that are followed by commercials. This pacing corresponds to the American child's attention span by stimulating their adrenal glands and conditioning children to become hyperactive. This cycle feeds the escalation of violence in our childhood population.

Regarding legislation:

- **CAM can elevate the level of the collective consciousness to shift a problem into a solution through the areas I have focused on above.**
- **Unify, coordinate and link CAM support.**
- **Designate legislative goals.**
- **Decide how CAM can best be presented to ensure majority support.**
- **Develop an organic action plan and a timetable for CAM goals to be accomplished.**

In conclusion, pollution and wellness are not compatible. Pesticides are found in the malignant breast and not in the benign breast. Pesticides and insecticides are eroding minerals and vitamins from our food. Because they are growing, children

have rapidly dividing cells in their bodies. These cells are far more susceptible to chemical damage. If the Center For Disease Control does spray the entire country with pesticides as a response to the West Nile Virus, childhood violence could rapidly escalate beyond it's current emergency.

Thank you for this opportunity to speak before your commission.

Sincerely,

Kathleen Quain
Globalpeace4U@aol.com

I am Kathleen Quain, a New York State licensed social worker, psychotherapist, with a background in public relations, marketing, broadcast production, and advertising. I am in private practice in Manhattan where I work with people who have been challenged with chronic and terminal illness, and work as a consultant on projects of integrity. As president of the Foundation For Health & The Environment, I speak for many who suffer from environmental health challenges.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: Epstein

Donald M. Epstein, D.C.
President, Association For Network Care

Paula Kim
Chairman of the Board and CEO
Pancreatic Cancer Action Network (PanCAN)

Oral Testimony of Donald M. Epstein, D.C.
White House Commission on Complimentary and Alternative Medicine
March 27, 2001

Hello Members of the White House Commission.

There is growing support for practices that enhance well-being and create a more functional, productive and quality filled experience of life.

Researchers within the University of California Irvine Department of Sociology and the School of Medicine have developed a revolutionary patient assessment instrument for wellness. This instrument examines the complex relationship between patient, lifestyle choices, life stress, various demographic factors and both biomedical and social science measures of wellness. Through self-assessment, it measures physical well-being, emotional/mental well being, stress, and life enjoyment and overall quality of life. The first of several resulting papers has been published pertaining to Network Spinal Analysis, a methodology I have developed.

This use of this instrument is not limited to those having symptoms or ailments. It is applicable to a wide range of schools of thought on wellness. Its use for measurement of self-reported health and wellness is detailed in a research paper attached to my written testimony.

The physician is skilled in knowing about the progression of disease, but it is only the patient who truly knows about their internal experience of health or wellness. In fact, a person's report of her own health and been shown to be one of the strongest predictors of her mortality.

Effective wellness outcomes are essential. Practitioners who care for individuals are often wrongly charged with excessive utilization in spite of the fact that an individual may continue achieving increasing levels of wellness in the practitioner's care. The consumer and practitioner alike must have the freedom to choose a wellness approach to health without engendering legal, financial or political sanctions.

Ineffective care must be distinguished from care that promotes overall health and wellness, with or without sole attention on a presenting complaint.

I know of patients who continue to reported pain in spite of the fact that they stopped drinking, smoking, or abusing family members. Others maintained their entrance complaints, but no longer accepted destructive aspects of their lives as being normal. There are even those who have advanced cancer, who are now feeling more alive, productive and well.

It was believed that treatment of disease and making positive lifestyle would produce greater wellness. It is now apparent that the treatment of disease and symptoms has little to do with enhanced wellness. It has also been demonstrated that constructive lifestyle choices do not predict enhanced wellness unless the person is also enjoying life more.

The inner experience of being ill is what drives individuals to doctors' offices for treatment. Treatment of disease and symptoms is a different path than seeking wellness. They are often mutually exclusive. Even with effective treatment of pain, or disease, if a person does not gain greater wellness, they often seek more treatment. Not only does this create greater cost, most often also results in diminished wellness.

The internal experience of wholeness, invincibility, flexibility, openness to life, and the ability to be in community is called wellness. Illness is the lack of wellness and a concern about one's health and mortality. Just as disease has little to do with the individual per se, but it is about classifying deviations from average, treatment of disease does little to impact upon illness. Illness and disease can in exist in the absence of one another.

Wellness is distinguished by a richer experience of life, and hallmarked by choices, which are more productive, efficient and bring greater life fulfillment. Outcomes assessments for wellness must incorporate such markers of healing. By redefining desired outcomes, clinical systems can then be refined to better fulfill patient needs, and create a new standard for health and wellness care.

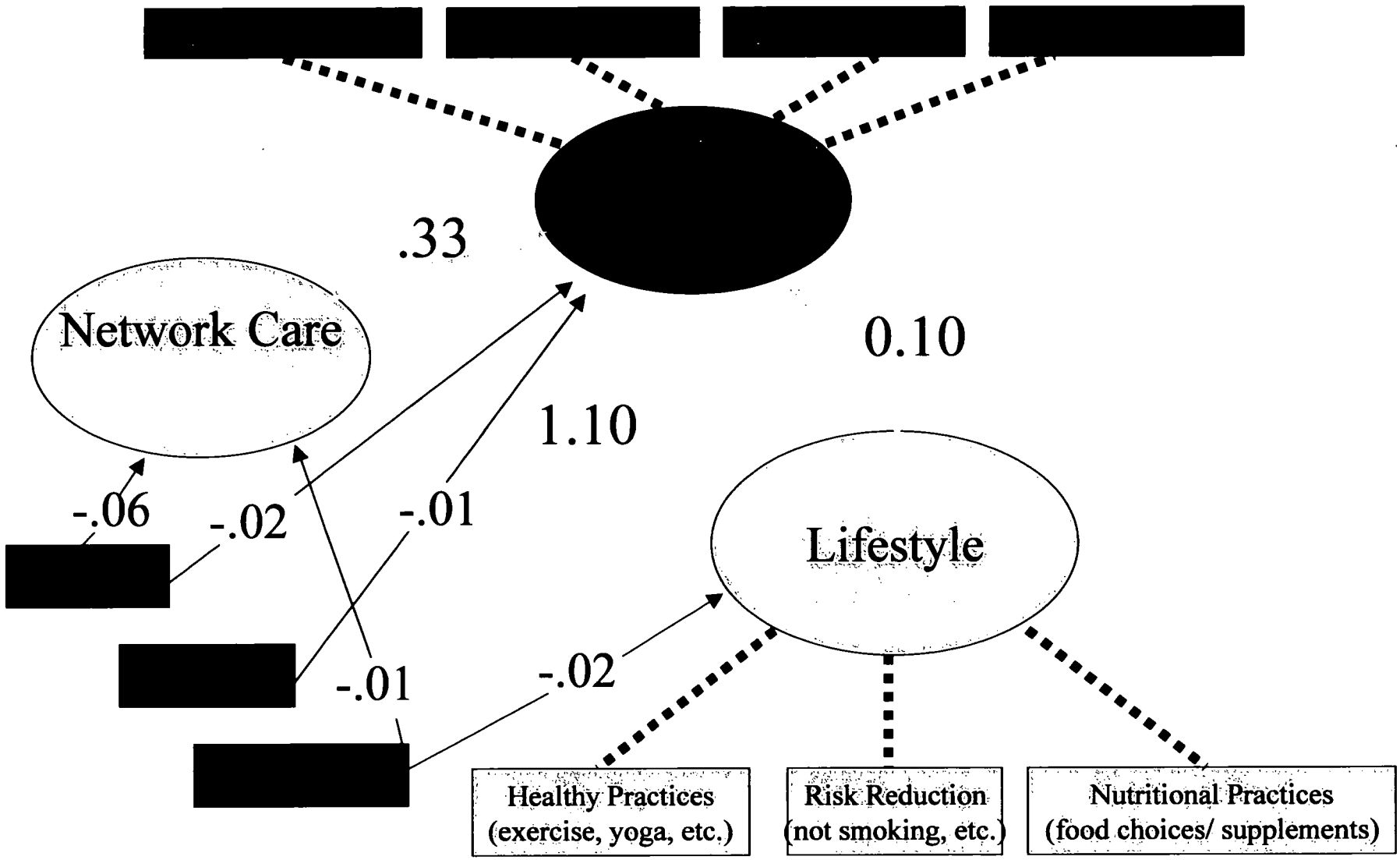


Figure 1: "Wellness" model derived from patient-centered data from 2,818 patients undergoing a form of chiropractic called Network Spinal Analysis (NSA). The cause-effect relationships between the "derived variables" in the ovals (NSA Care, Wellness, Life Changes, Lifestyle) and the actual items on the questionnaire in rectangles (independent variables) is determined statistically using Path Analysis (for additional details see text). The solid arrows indicate the ordered, cause-effect relationships predicted by the data; the dashed lines indicate the actual variables significantly related to each derived variable. Note that care impacts wellness directly, and indirectly by promoting beneficial lifestyle changes. In this model, lifestyle promotes wellness only indirectly by impacting life enjoyment.

Written Testimony of Donald M. Epstein, D.C.
White House Commission on Complimentary and Alternative Medicine
March 27, 2001

Donald M. Epstein, D.C. is the developer of Network Spinal Analysis, a system that evolved from the subluxation-based-wellness chiropractic model.

He is also the developer of SomatoRespiratory Integration. This self-help application assists in developing Somato-respiratory awareness and is purported to advance states of consciousness. He is the author of both the 12 Stages of Healing and Healing Myths Healing Magic (Amber-Allen) and of various articles and other publications. He is an international instructor of his methodologies and a highly sought after speaker.

Through the Association for Network Care, he has instituted an ambitions research agenda. The ANC, along with researchers within the University of California Irvine Department of Sociology and the School of Medicine, has produced a revolutionary patient Questionnaire for measuring wellness. This instrument assesses the complex relationship between patient, lifestyle choices, life stress, various demographic factors and both biomedical and social science measures of wellness. It is specifically a non-medical questionnaire. It can assess individuals experiencing excellent health and wellness status, even in the presence of specific disease or symptoms. A longitudinal study has been completed adding to the body of evidence supporting the validity of this instrument and the wellness benefits of Network Spinal Analysis care.

A copy of the retrospective study of Network patients is included in this package. Several additional papers are nearing completion; two of these papers are anticipated to be included at the research meeting of the Commission.

It is anticipated that this instrument will become the "gold standard" for wellness assessment, replacing other current instruments and allowing for self reported wellness to be

measured. Its uniqueness rests in its design which eliminates the confounding factor of a ceiling to wellness found in other current instruments oriented to the allopathic or medical model.

The "Somatopsychic" wave is a spontaneous spinal undulation characteristic of NSA care also being studied. It is associated with a significant increase in wellness, and is thought to enhance spinal and neural integrity. This wave has been the topic of study at the University of Southern California department of Engineering and has been presented in November 2000, at a conference co-sponsored by the National Science Foundation. Research has demonstrated that this characteristic of NSA care is a non-linear (dynamical) event. When studied utilizing surface electromyography (EMG) the signals becomes increasingly complex as care progresses. Based on these findings it is proposed that the nervous system is self-organizing. Individuals experiencing this wave make healthier choices, experience greater life enjoyment and report a significantly higher level of wellness.

Marnie Dobson, co-author of the papers on the retrospective and longitudinal surveys of patients in Network Care, was recently awarded a grant though a center for tobacco addiction in relationship funded by the National Institutes of Health. This supports the study of the Network Care population in relationship to cessation of smoking.

Compelling recent data will be reported in papers to be presented at the research meeting of the Commission. People choosing to remain in long term NSA care long term (over 3 months) show striking differences from those dropping out of care early in that they:

1- do not have chronic ailments
2- are aware of the clinical outcomes (waves) earlier
3- are eight times more likely to self-report positive changes in health, wellness, and quality of life with the care
4- have a higher average family income.

These findings demonstrate that wellness practices are attracting a different, more health conscious population then that attracted to disease care.

One would think that simply making healthy lifestyle choices (diet, exercise, meditation, non-smoking, etc.) would predict greater wellness. This has not been shown to be true unless greater life enjoyment also resulted from care. **Remarkably Network care is rated as being 3 times more effective in promoting wellness than lifestyle changes alone.**

Dr. Epstein, along with Robert Blanks Ph.D. , is the architect of a new certificate/Master's Degree program, which is expected to be accepting its first class in the fall of 2001. This program will guide students in wellness outcome assessment consistent with the instrument mentioned above. It will help assess patients' self- reported changes in wellness referred to as the "Wellness index". This concept will bridge biomedical, social sciences, and the more "spiritual" assessments of wellness, including the role that life enjoyment plays in improving health.

It should be noted that in some states chiropractic regulation has either banned (Wisconsin) or deemed unproven (Colorado) ***"any practice system, analysis, method, or protocol which is represented as a means of attaining spiritual growth, comfort or well-being".*** Practitioners have had sanctions taken against their license for not issuing a written notice of informed consent for practicing an "unproved method". **This was simply because of the association with this wellness model.** The acceptance of the broader wellness model, when combined with specific patient reported outcome assessments, and practitioner clinical review, will help assure the delivery and promotion of wellness care to the public.