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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESPONSE TO WHITE HOUSE COMMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

February 13, 2001

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

Dear Dr. Kaczmarczyk and White House Commission Members;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

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

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

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

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

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

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

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

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

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

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

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

Good afternoon Commissioners;

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

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

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

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

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

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

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

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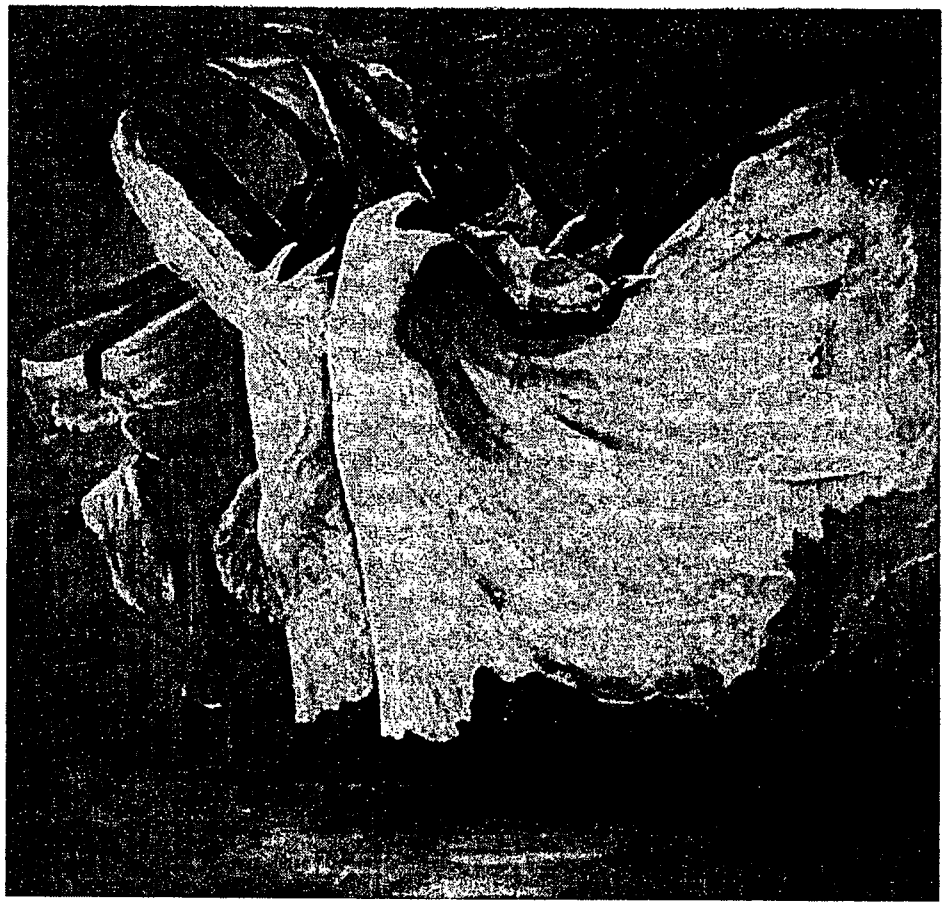

Honoring Our Uniqueness

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.

MAH_ _LLUS 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[illegible]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

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

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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.

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.

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[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."

Prayer-based healing has a very long history and pre-dates the current interest in CAM. It has been accommodated for decades in the U.S. on what might be called a "spiritual track" within healthcare.

Not every remedial method needs to be incorporated into the medical model. The system of self-care established by Alcoholics Anonymous is a good illustration of an approach that does not incorporate well into the medical model. Christian Science is another.

Christian Science is a system of prayer-based healing that's explained in a reference book by Mary Baker Eddy, titled, *Science and Health with Key to the Scriptures.* This system of self-care has been successfully practiced for over 130 years, providing both preventive and therapeutic benefits.

The Christian Science system of healing also includes a provision for assistance, if needed. For example, Christian Science practitioners, nurses and religious non-medical nursing facilities are available for individuals using this method of treatment.

Also, Christian Science healing is accommodated in law, health and disability insurance programs, and health insurance plans that cover state and federal employees. In addition, Part A of Medicare provides coverage for nursing care given at religious non-medical healthcare institutions, including Christian Science nursing facilities.

The Christian Science system is a modern-day illustration of free market choice and government accommodation for prayer-based healing, without medical supervision, regulation, or control.

We ask, therefore, that the Commission acknowledge a spiritual track in support of patient self-care and personal wellness.

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THE
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• SPECIAL REPRINT •

Christian Science healing methods *explained*

From the Harvard Symposium "Spirituality and Healing in Medicine"

Reprinted from *The Christian Science Journal*, March 1999

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.

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.

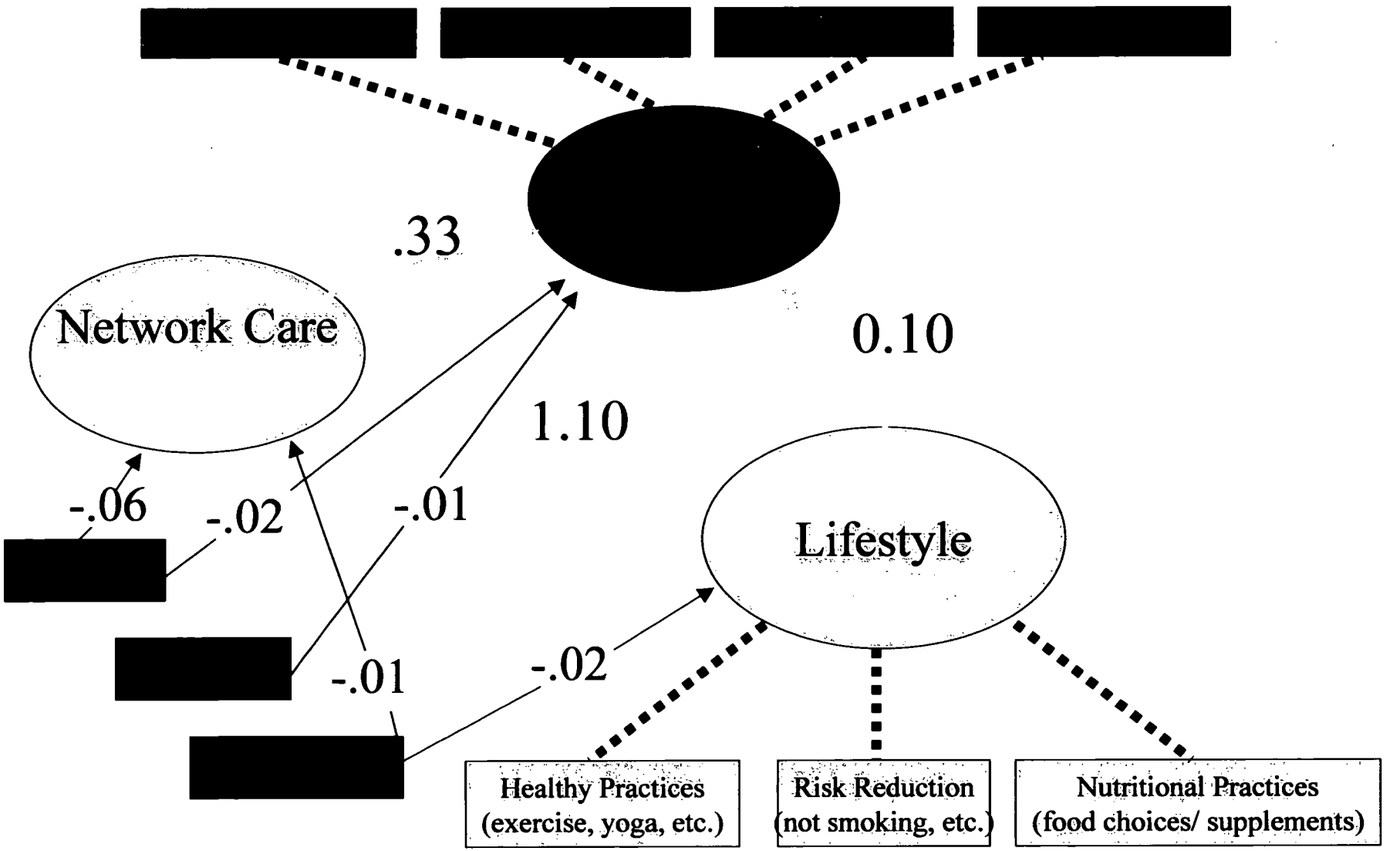

Figure 1: "Wellness" model derived from patient-centered data from 2,818 patients undergoing a form of chiropractic called Network Spinal Analysis (NSA). The cause-effect relationships between the "derived variables" in the ovals (NSA Care, Wellness, Life Changes, Lifestyle) and the actual items on the 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.

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ORIGINAL RESEARCH

A Retrospective Assessment of Network Care Using a Survey of Self-Rated Health, Wellness and Quality of Life.

Robert H. I. Blanks, Ph.D,[1,2]
Tonya L. Schuster, Ph.D,[3] *Marnie Dobson, B.A.*[1]

Abstract — The present study represents a retrospective characterization of Network Care, a health care discipline within the subluxation-based chiropractic model. Data were obtained from 156 Network offices (49% practitioner participation rate) in the United States, Canada, Australia, and Puerto Rico. Sociodemographic characterization of 2818 respondents, representing a 67-71% response rate, revealed a population predominately white, female, well-educated, professional, or white collar workers. A second objective of the study included the development and initial validation of a new health survey instrument. The instrument was specifically designed to assess wellness through patients' self-rating different health domains and overall quality of life at two "time" points: "presently" and retrospectively, recalling their status before initiating care ("before Network"). Statistical evaluation employing Chronbach's alpha and theta coefficients derived from principle components factor analyses, indicated a high level of internal reliability in regard to the survey instrument, as well as stable reliability of the retrospective recall method of self-rated perceptions of change as a function of duration of care. Results indicated that patients reported significant, positive perceived change ($p < 0.000$) in all four domains of health, as well as overall quality of life. Effect sizes for these difference scores were all large (>0.9). Wellness was assessed by summing the scores for the four health domains into a *combined wellness scale,* and comparing this combined scale "presently" and "before Network." The difference, or "wellness coefficient" spanning a range of -1 to +1, with zero representing no change, showed positive, progressive increases over the duration of care intervals ranging from 1-3 months to over three years. The evidence of improved health in the four domains (physical state, mental/emotional state, stress evaluation, life enjoyment), overall quality of life from a standardized index, and the "wellness coefficient," suggests that Network Care is associated with significant benefits. These benefits are evident from as early as 1-3 months under care, and appear to show continuing clinical improvements in the duration of care intervals studied, with no indication of a maximum clinical benefit. These findings are being further evaluated through longitudinal studies of current populations under care in combination with investigation of the neurophysiological mechanisms underlying its effects.

Key Words: Network spinal analysis, vertebral subluxation, chiropractic, self-rated outcomes assessment, wellness, overall quality of life.

Introduction

Network Care is a health care discipline within the subluxation-based chiropractic model[1] practiced by members of the Association for Network Chiropractic (ANC), nationally and internationally. Building from a base of consistent clinical observations, and repeated anecdotal reports of health benefits, the present study was conducted to fulfill the following three objectives: (1) to characterize the patient population undergoing Network Care; (2) to develop a new survey instrument of sufficient design and scope to allow assessment of a non-medical health discipline, and (3) to assess changes in patients' self-rated health, wellness, and overall quality of life.

Network Care is founded on the premise that individuals free of the complex of factors precipitating from, or leading to, vertebral subluxation experience a greater range of inherent adaptability and, hence, a greater sense of relative health or wellness. In a large percentage of individuals, Network Care evokes spontaneous self-perpetuating contractions of the paraspinal musculature.[1] The movements may be subtle, barely perceptible, or very

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

March 27, 2001

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion and Recommendations

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

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

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

Wellness and End of Life Care

White House Commission on Complementary
And Alternative Medicine Policy

Meetings on Complementary and Alternative Medicine in Self-Care and Wellness
and Information Development and Dissemination
March 26-27, 2001

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Spirituality is an essential aspect of end of life care and one that deserves prominence in our healthcare system. Spirituality can be defined as that which gives a deep meaning and purpose in a person's life and often how people cope with suffering. Spirituality can have many expressions: in religion, art, family, other spiritual beliefs.[1] National surveys show that people value the spiritual dimension in dying. Also, other data shows that people utilize their spiritual beliefs to help them cope with chronic illness and with dying. We who work with patients know the importance of spirituality for those that are seriously ill. I propose three initiatives that would help patients at the end of life.

The first initiative is: Spiritual care should be made available in all settings in which the terminally ill are treated.

The second initiative is: Healthcare professionals and faith communities need to be trained in recognizing the importance of spiritual care particularly at the end of life.

The third initiative is: Spiritual care should be reimbursed by medicare and other third party insurance.

Extend hospice care beyond 6 mos

1. Spiritual care should be made available in all settings in which the terminally ill are treated.

A recent survey by George Gallup polled Americans about what their needs would be if they were dying.[2] The two major needs demonstrated in this survey were that people want:

- Companionship – people do not want to die alone and they want warm, caring relationships with their physicians; and
- Spiritual comfort – such as receiving blessings from their clergy, living on through their relationships and their accomplishments.

The conclusions from the Gallup survey and other surveys is that it is as important for healthcare providers and other caretakers to talk with patients about these issues as it is to address the medical-practical side of care.[3,4]

There is also data that suggests that spirituality may be helpful to people as they cope with dying. For example, patients with advanced cancer who also found comfort from their spiritual beliefs were more satisfied with their lives, were happier and also had diminished pain.[5,6] In a national survey by the American pain society, prayer is the most common non-drug method for dealing with pain.[7] Patients with cancer and AIDS felt that their spiritual beliefs helped them cope with their illness and with facing death.[8] There is also data on the role of the beneficial effects of meditation termed the relaxation response by Dr. Herbert Benson, as an adjunct to treatment of patients with serious illness.[9] Spirituality offers people hope in the face of the despair that can occur in the course of serious illness and dying. Initially the hope may be for a cure; when cure is no longer possible, the person may hope for time to finish old projects, making peace with loved ones, with God, and have a peaceful death.

It is critical that our systems of care allow people to have the opportunities to explore their spiritual issues. Spiritual care means:

- All care providers should address the spiritual issues of patients and be trained to respond

to those issues;

- Chaplains (CPE trained) and other spiritual care providers should be recognized as experts and as members of the interdisciplinary healthcare teams in all settings: outpatient clinics, hospitals hospices, nursing homes, etc.;
- Patients' hopes, dreams, fears and anxieties should be respected and listened to just as much as their symptoms; and
- Opportunities should be made available for reflection, prayer, and meditation (specifically, the teaching of the relaxation response to patients).

2. Healthcare professionals and faith communities need to be trained in recognizing the importance of spiritual care particularly at the end of life .

Right now, through a program I direct, there are courses in over 70 medical schools, and several residency programs on spirituality and health.[10,11,12] The response to these courses has been overwhelmingly positive. Physicians want to be responsive to the holistic needs of their patients. Physicians, nurses and clergy want training in spirituality and end of life care. Faith communities are available and willing to minister to those patients who are ill and dying but often feel unprepared. Training programs are essential for all these professional caregivers. These programs should address:

- The role of spirituality in health and in end of life;
- How to address patients' spiritual needs;
- How to recognize spiritual suffering;
- How an interdisciplinary approach to care can build communities of caring (i.e. doctor, nurse, chaplain, social worker, family, faith community all caring for patient together); and
- For clergy and faith communities – how to recognize end of life symptoms, spiritual suffering and how to work within the health care systems.

3. Spiritual care should be reimbursed by medicare and other third party insurance.

The data as well as anecdotal experiences from physicians and other care providers demonstrate

that spirituality is very important particularly in chronic illness and in end of life care. However, our healthcare systems are driven by reimbursement. Physicians while wanting to take the time to do spiritual counseling are often prevented due to time pressures and reimbursement restrictions. Chaplains in out patient settings need to be reimbursed for their time. There is one program in Colorado called Sloans Lake that reimburses chaplain visits in the outpatient setting. The relaxation response is a clearly defined technique which can benefit patients and which could be reimbursable. Therefore, important aspects of care such as spirituality need to be supported and must be reimbursed because they are vital to the needs of patients.

In summary, spirituality is important in well being at the end of life. My recommendations are for the following initiatives:

1. Spiritual care should be made available in all settings in which the terminally ill are treated.
2. Healthcare professionals and faith communities need to be trained and supported in recognizing the importance of spiritual care particularly at the end of life .
3. Spiritual care should be reimbursed by medicare and other third party insurance.

These three initiatives will help the terminally ill patient and their families at a time of crisis in their lives. Dying is one of the most difficult things any of us will face. We need to create systems of care that will recognize not only the physical dimensions of care but also the spiritual. By recognizing this important dimension we will transform our healthcare systems from a cold impersonal system to one that is a caring community where all patients' and families' needs could be met.

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SPIRITUALITY & MEDICINE CONNECTION©

Volume 4, Issue 2, Summer 2000

RELIGIOUS INVOLVEMENT AND MORTALITY RISK

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In the last decade, many researchers have found that religious involvement is related to lower risk of early death. Most recently, a meta-analysis identified 42 study samples that investigated the link between religious involvement and some measure of mortality[1] *(Please see page 4)*. Nearly all of the studies on the this topic have examined frequency of attendance at religious services (or similar measures of organizational participation)[2-9]. A handful of investigators have considered other aspects of religiousness, such as receiving strength and comfort from religious faith[10]. Among the most recent and methodologically sophisticated studies, Strawbridge et al.[7] found a negative association between frequent religious attendance and all-cause mortality in a 28-year follow-up of residents of Alameda County, CA. This association was only partly mediated by health practices and social ties, and the association was somewhat stronger for women than for men.

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

With few exceptions[2], investigators in this area have used predominantly non-Hispanic white samples. The lack of explicit attention to racial and ethnic minority groups is particularly unfortunate given the institutional centrality of religion in several minority communities. We recently sought to fill this gap by closely examining religious involvement and mortality risk among a nationally representative sample of African-American adults[11]. African-Americans who reported not attending services at all experienced over twice the risk of death in the follow-up period compared to their counterparts who reported attending more than once a week. This differential is larger than what has been shown to exist among the general population of the U.S. Religious non-involvement was linked with a greater risk of mortality for most subgroups (e.g., ages 18-54 and 55+, women and men, southerners and non-southerners) of the African-American population. In most instances, these patterns persisted despite statistical adjustments for a wide range of confounding factors (e.g., sociodemographic variables, SES and health selectivity) and mediating factors (e.g., health practices, social ties and support). It is clear that the relationship between religious involvement and mortality risk should also be examined within other minority populations.

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

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CAM, WELLNESS, AND SELF-CARE AND THE ELDERLY

An 85 year old has been healthy all of his life - a great outdoorsman who loves fishing, gardening and walking in the woods. He has always been active in a local church and is surrounded by a loving wife, 2 children, and many grand and great grandchildren. He developed angina when he walked the hills in his neighborhood and, on further evaluation, it was determined that he had significant coronary artery disease and he underwent bypass surgery. He fully recovered from the surgery and went back to his usual activities, albeit on several new medications. Several years later, he developed a case of shingles, or herpes zoster, for which he was treated. However, he developed chronic herpetic neuralgia and was disabled by the pain. Over the next 6 years, due to severe pain, he declined to the point where he was only out of bed for several hours per day, he gave up gardening, and it was even painful for him to be embraced by his family. In spite of the pain, he continued to walk daily until one of his pain medications made him so clumsy that he fell and broke his nose. After that incident, he was afraid to walk. He tried other medications and even a nerve block for the pain but none of these interventions helped his pain and all caused side effects. His physicians told him that they had no other options for him - that he would have to live with pain. This man is my grandfather, and as I began to explore the possibility of CAM with him I found that not only was it difficult to find practitioners who were accessible to him (he no longer drives), but he was unable to afford the fee for a treatment course.

I'm sure you have heard stories like this many times today and at other times in your work. My grandfather's story helps illustrate some of the points I would like to make related to the use of CAM to promote wellness and self-care in older adults.

By the year 2020, 20% of the world population will be over 65 years. In the U.S., 8% of the population is currently over 65 years and in 2020, it is estimated that 25% will be over 65 years (roughly 65 million older adults).

There is a wide variety in apparent rates of aging among different persons. This individual variation in physiologic efficiency increases with advancing age. Thus, the older adult population is quite heterogeneous with a large proportion that has aged successfully and continues to have few or no chronic conditions while others have multiple diseases and excess disability. In a population study, approximately, 14% of men and 24% of women between the ages of 65-74 years reported some disability. In the age group over 75 years, 23% of men and 41% of women report disability. In older adults, functional status is the most important marker for wellness. When we see patients for an initial evaluation or in follow-up we use standardized measures to determine physical, emotional and cognitive function. These functional measures help us to really understand how patients are doing - even if they do not have any increases in disease-specific symptoms. Frequently, these measures are the first indication that a particular disease process or the burden of multiple diseases is worsening. Likewise, improved functional status is an early indicator that the patient's overall health is improving. In older adults, wellness is related to maintaining or improving function rather than the prevention of specific diseases. We know that even those adults with high levels of disability can and do experience long-term improvements in functional status when some targeted intervention is provided. This implies that we need to provide access to CAM to older adults across a spectrum of function and across a number of living situations (community, assisted living, nursing homes).

Encouraging self care and wellness in older adults involves 2 important tasks: education of those who already believe that they can participate in their own care and want to be involved and empowerment of those who are skeptical about self care and want the doctor to provide a silver bullet that will make them 'well'. While these issues are not unique to older adults, the current cohort of 85 year olds may require more empowerment (followed by education) than baby boomers when they are 85 years old. In addition, one must consider the different needs, related to CAM, of those who are aging in what we consider a 'usual' manner compared to those who are aging 'successfully'. With usual aging the goal is to maintain or

improve function and quality of life. With successful aging we would add disease and disability prevention.

One of the major concerns in older adults is polypharmacy, the use of multiple medications. Older adults constitute about 12% of the population but consume approximately 25% of prescription medications each year. It has been estimated that older North Americans take an average of 4.5 medications at any one time. Most of these patients are taking prescription and over-the-counter (including more nutriceuticals) medications. Further, several studies demonstrated that the number of adverse drug effects increases dramatically with the number of medications (from 15% with 2 medications to 50-60% with 5 medications). CAM may well reduce the number of medications older adults take, particularly since the major classes of medications used by older adults treat diseases that have been shown to benefit from one or several CAM modalities (cardiovascular, antihypertensives, analgesics, arthritis, psychotherapeutics), at least in younger patients. In geriatrics we use a framework for adjustments of drug therapies, considering concomitant diseases and a knowledge of drugs that are likely to be co-administered in older patients, along with guidelines for adjustments in dosing or drug combinations to optimize beneficial effects and avoid adverse effects. CAM could be integrated into this framework and result in improved care for older adults.

On the other hand, older adults are typically more sensitive to medications and frequently require reduction of dosage to minimize adverse effects. It is possible that the same is true for CAM, particularly herbal remedies and vitamins, but also for other modalities, such as energy medicine. As we begin to integrate different systems of care, it is important to be aware that changes in the body that occur with aging predispose older adults to adverse events and that 'starting low and going slow' should be the modus operandi until studies more clearly document safety in older adults specifically.

Reimbursement of services and access to care are challenges that particularly affect older adults. Even in an affluent state such as Connecticut, many older adults live on fixed incomes and are unable

or unwilling to pay out of pocket for CAM - even if these modalities could potentially save the health system money. Further, practitioners may accept other forms of insurance but are reluctant to consider Medicare (even if the treatment is covered) because of the more rigorous criteria for reimbursement and the administrative time and costs. As we begin to think about long-term solutions for reimbursement for CAM, we must find solutions that include Medicare so that a group of patients who could potentially benefit greatly from this type of care are not excluded from it.

Access to care is also an issue for older adults who are not able to drive or who rely on family members or public transportation. Centralized facilities, in which multiple care providers practice, would enhance access to care for older adults. In addition, these centralized services would increase the opportunity for various practitioners to collaborate on the care of individual patients.

In geriatrics, the multidisciplinary team is basic to our way of practicing medicine. Geriatricians already work with and value the input of health care providers who are not trained as medical doctors, such as nurses, physical and occupational therapists, nutritionists and social workers. Integration of CAM providers into a geriatrics care team would enhance the work of the team and provide more holistic and, perhaps, cost-effective care for older adults.

Recommendations:

1) Education

   In order to increase CAM knowledge of patient and allopathic medical personnel, we need to have educational plans for older laypersons and training for physicians at all levels. Broad dissemination of research results is necessary and this is already happening through the NCCAM web site and newsletter. Increase training of physicians who care for older adults on the use of CAM through formal on-site and distance learning models. Emphasize differences in care of older adults related to CAM medicine. Teach health care

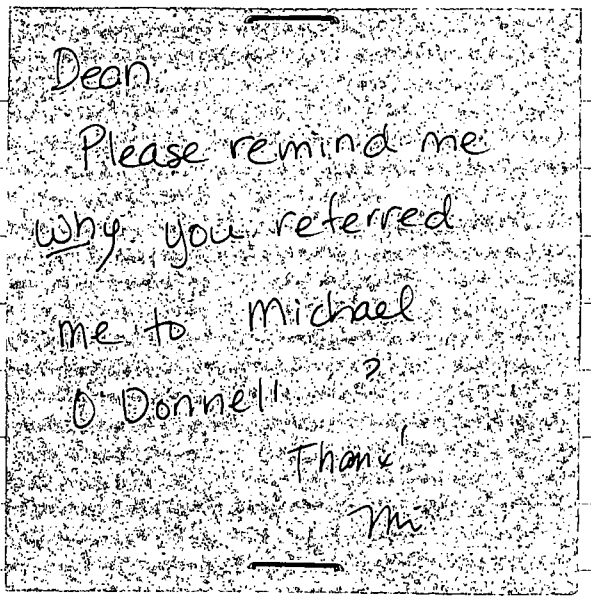
professionals about self-care and the importance of leading by example.

2) Research

It is important to make sure that adequate numbers of older adults are included in planned intervention trials. Collaboration with NIA on research in a variety of areas (in addition to areas already being explored) is vital. Research on CAM modalities in older adults must include adequate measures of functional status, quality of life and evaluation of adverse effects. Cost-benefit analysis is an essential part of research protocols so that we can better understand how/if reimbursement through Medicare should be modified.

3) Clinical care

Models in which allopathic and CAM providers are centrally located will likely make care more accessible for older adults. The multidisciplinary team approach is already a standard approach in geriatrics and integration of CAM into existing teams (and reimbursement to support team) would be relatively simple to implement. Reimburse CAM for older adults (and sponsor more research to support its use).



Michael is President + Editor in Chief of the American Journal of Health Promotion. He is leading an effective initiative to bring health promotion & disease prevention into the legislative arena. They had a major conference here in DC Feb. 14-16.

Since so much testimony here talked about the need for legislative reform, there is a lot of overlap.

He's a good guy.

Also - George Bernier is now working for Senator (D-IL??)