Commission about how to do that?

DR. SENSENIG: Well, specifically, as relates to naturopathic medicine, we would like to see the encouragement or a statement, or a position, encouraging the states to license naturopathic physicians and other CAM providers, as is appropriate.

This issue of credentialing and licensing, or certification as a prerequisite to reimbursement was discussed in detail by the Commission, I think, yesterday. We have an interesting situation in Connecticut that I would share with you. In our state it is mandated that any plan that covers the services of a medical doctor or an osteopath, also cover the services of a naturopathic physician.

So that is true for all the insurance plans in the state, except for those folks who are federal employees or who are receiving Medicare, because those benefits don't accrue to those patients at the federal level.

The other thing that we would like to see as a result of discussions here would be parity for, in this case, all schools of physicians at the federal level. We

are not asking, necessarily, for any special treatment, but rather for parity with other schools of physicians. Again, we may be a minority school, but we are still a recognized school.

I was discussing this with some people at lunch today, and we were wondering how much our federal government transfers to conventional, and not to other schools of medicine, including osteopathy and naturopathy.

Does that answer your question, Joe?

DR. GORDON: Other questions? Don.

DR. WARREN: Ms. Cole, you were talking about that CAM preys on the vulnerability of susceptible patients. Don't you feel that maybe the apparent feeling of being railroaded into conventional therapies where there is no hope of cure is also preying on the vulnerable?

MS. COLE: I think, to a certain degree, it probably is. What I see, sometimes, with the elderly, in being preyed upon by people who are trying to make money -- and certainly it happens in all areas of our lives -- what I am referring to there when I am talking about it,

is that when we look at cancer patients and the state of mind that they are in when they are diagnosed with cancer, they are desperate to find a cure. Many times, when we are diagnosed, we still think death; we don't think cure.

We want to try anything that might help. When we see something on the Web, or anywhere, that has a testimony of a cure, then someone is going to try that, many times. That is what I am thinking when I say that lots of times, when people advertise, they are thinking about the cancer patient, really, as much as they are any other person who has a serious illness in their being desperate to find something.

DR. GORDON: Other questions?

DR. WARREN: Isn't one of the main things that happens is that it dashes all hope for people? Once you dash hope, then they are more susceptible to going into surgery. I feel that a lot of these people have lost hope in being able to be cured at all.

I don't think that being preyed has anything to do with it. I believe that people that give people some hope, maybe not a cure, but just some hope of maybe a

better quality of life. I don't see that that is being preyed on. I may be wrong, but that is what it looks like.

MS. COLE: Well, again, if I can use my analogy of elderly people who have the hope of having their roof fixed, say, people are more likely to knock on their doors because they know that they are going to be more likely to say yes to a therapy.

DR. WARREN: But we are running to ethics, though. We are running into the ethics of the practitioner, and the ethics of the practitioner can't be dictated.

That comes into both ways. If you are ethical and they need the roof fixed, then they get the roof fixed. If you walk in and you are not ethical, I don't care if they have got a brand new roof, it needs to be fixed. That happens in all professions. It is not just in CAM. It is in conventional medicine, it is in conventional dentistry, it is in every single aspect of our society today.

I am not going to argue, but -- yes, I am.

MS. COLE: My intention is not to do that,

either. Our point in this really has more to do with, yes, when patients lose hope, that definitely plays into what decisions they make, regardless of what kind of therapy they get, whether it be allopathic or otherwise. There is no question about that.

I am trying to understand your point, and thinking that whether you are saying, don't you think that happens in the medical world as well. Possibly, it does, but wherever it happens, we want to make sure that our patients get the right information about what works and what doesn't. If they choose, still, to use it, that is their right.

Again, it applies to both worlds. We are talking about complementary and alternative medicine here today, and so that is why we say it in relation to that today. I really am not disagreeing with what you are saying about it happening in the other worlds as well.

DR. WARREN: One more question to Ms. Pittman. yes or no, is the American Dietetic Association feel like they are the only qualified to use nutritional supplementation in helping people heal themselves?

MS. PITTMAN: The American Dietetic Association

feels that their members are well qualified to help consumers understand or incorporate supplements, or other nutritional complementary medicines, into their plan.

DR. WARREN: Are you specifically trained in the use of dietary supplementation?

MS. PITTMAN: Many members of ADA are specifically trained in the use of dietary supplements. We have a Dietetic Practice Group.

DR. WARREN: But not everybody.

MS. PITTMAN: Not across the board. There are specific practice groups.

DR. GORDON: Wayne, go ahead.

DR. JONAS: Candace, can you give us an idea of where access is on the Hill. Is the support growing for it? Is there a critical mass? Is it being attached to anything else? What is the likelihood that this is going to get looked at this year in a serious way or be addressed?

MS. CAMPBELL: We have been promised that this is our congress. We have been waiting for six years, patiently. Other things like Medicare reform and FDA reform were way ahead of us.

We have always enjoyed very strong bipartisan support. It has never become a partisan issue. My reaction is, based on what we have heard from the Bush Administration and HHS, to date, that it is no longer a hostile environment, where it was under the previous administration.

So I am very hopeful that if we make a full court press on the bill in this congress, that it will get very serious attention. I don't think it is the kind of bill that would stand on its own, but there are so many health bills moving, that it would probably be attached to something that looks like a must-pass vehicle.

DR. JONAS: The Bill of Rights, is it all related to that?

MS. CAMPBELL: Well, we probably should have called it that, but we didn't. They got it first. I don't know, I think the Patient's Bill of Rights is so controversial that they would hate to add an anchor. The Access Bill will be controversial on its own, so they will probably attach it to something less heated.

DR. GORDON: Linnea, and then Joe.

MS. LARSON: My question is kind of speculative in nature, and so any of you who wish to comment. It is not quite formulated.

One of my concerns, really, is the medicalization of culture. I don't want to go into an art museum and think that that is my daily dose of art. I want to be able to go into an art museum to have the experience of art, or, listening to Bach, I am listening to Bach, not with the express purpose that my immune system is going to be bettered.

My question really is a philosophical question. Perhaps we can say those who use these specific modalities within a medical system, allopathic or whatever, we could consider being reimbursed, but I am really questioning whether or not all of culture is being put to the test of simple medicine.

MS. SIMPSON: In responding to that, I do think there is a place, obviously, for the arts for our own aesthetic pleasure and for our own benefit and growth, personal, social, emotional. When it comes to the application of music therapy, however, I look at it separately because your goals are non-musical. The goals

are not music as an end, but music as a means to get to the end, music as a means to effect a change behaviorally, emotionally.

So it is applied in a different way than the "therapy" you might receive in going to a concert, or the benefit or aesthetic pleasure that you have from that experience, because I do think that is something that we all need to have in our lives, but it is a separate aspect, and different from the application of music therapy in a clinical setting.

MS. Di MARIA: I work with severely emotionally disturbed children here in the city, and a lot of them, because of their difficulties have trouble verbalizing their concerns. Most of them love art therapy. One five-year old with whom I work calls it art thirsty.

So they come, and it is easier to make a picture of something that is going on at home or someone being bullied in the classroom -- well, hopefully not the classroom, but in the neighborhood, wherever -- and then we can talk a little bit more easily about it by talking about what is going on in the picture.

DR. GORDON: Joe.

DR. PIZZORNO: Candace, I would like to thank you for the fantastic work you have been doing here in Washington to improve health freedom. It has been really quite impressive.

MS. CAMPBELL: Thanks.

DR. PIZZORNO: You made some fairly strong statements about the FDA, and I would like to ask your opinion on something. We have been discussing suggesting to Congress to create a new branch of the FDA to regulate nutritional medicines or dietary supplements, whatever term you want to utilize, for this.

Would you comment on what might be the pros and cons of such an action?

MS. CAMPBELL: I don't think there is any fixing the FDA when it comes to this. I would certainly like to look at a proposal that recommended a separate way to address natural products. I wouldn't put it at FDA. It is a little bit like putting the Office of Alternative Medicine at NIH. You can do it, but it is putting them right in there with the sharks. So I think it may be the only solution.

I believe Canada has done this recently, with a

separate branch that handles natural products. Maybe they haven't done it long enough to give us any kind of a track record, but I wouldn't put it at the FDA. I don't think that they are capable of changing this very entrenched bias against nutritional products. It is really not a system that can be fixed. They are not willing to fix it.

DR. GORDON: I have two quick questions. I think they are quick. The first is for both of you, both Audrey Di Maria and Judy Simpson.

You spoke about research funding. Do you feel that the access to funding is not currently adequate? I mean the access, not the funding.

MS. SIMPSON: No. In fact, it seems like the methods to getting to that access, getting to those funds is very difficult. It has been, perhaps, related to the fact that our cadre of researchers is not large enough -- or, well-trained researchers to do the quality research.

I know that there a lot of therapies out there attempting to increase our amount of research, but they may not be adequately trained in doing the appropriate type that we need to affect reimbursement issues.

MS. Di MARIA: I will agree with that, that up until the past 10 years, we really didn't have a lot of research courses in the training programs, and we are trying to rectify that.

DR. GORDON: One of the things that we heard earlier today -- I don't think that you were here earlier when Nancy Pearson and Neal West from NCCAM spoke -- is that they have programs to train researchers, and they have research fellowships. I think that you ought to look at the NCCAM website and speak with one or the other of them about those opportunities, because they are interested in expanding it to all the different health/mental health professions.

MS. SIMPSON: I know we had communications with AHRQ in the last year and a half in looking at what opportunities, in particular music therapy, in accessing some of the funds that they have for research. So it has been a process, but it isn't something that we have had success with yet.

DR. GORDON: My suggestion would be you speak to them and you talk with them, and speak to them about your concerns. Let us know how that goes, because I

think it is very clear that they are trying to reach out to provide research training to the entire field, and that you would certainly qualify.

Candace, I wanted to ask a question, which may or may not be quick. I wonder if you could elaborate just a little bit more on your concern about DSHEA, because I gather what you are saying is the provisions are there in DSHEA but they are not being adequately implemented.

If you could just give, real quickly, a couple of examples of how that is, just so that we can begin, and then maybe later on we can speak with you more about getting more information.

MS. CAMPBELL: Well, you probably know that the big debate, when DSHEA was being considered, was whether and how to allow health claims. Congress clearly wanted there to be an increase in the amount of information provided about supplements to the American public.

The bill was jammed down the throat of the FDA, and they have spent all the ensuing seven years trying very hard not to abide by that. One of the ways they have done that is with their Significant Scientific

Agreement standard, which is never defined.

We are not allowed to have cops pull us over for speeding when the speed limit is not posted. So if you don't have a standard by which to judge health claims, none of them are ever approved. So that was the gist of our court case. We didn't think it should have been necessary because it was clear in DSHEA, but the Agency was not abiding by the will of Congress or the law.

I can give you a perfect example. Folic acid health claims, as they relate to the prevention of neural tube defects. That is a no-brainer. I think it has been about 12 or 13 years that CDC has been publicizing that. Doctors have been telling their patients this for years. A year or two ago, the FDA even encouraged food manufacturers to supplement bread products with folic acid. They would not allow a health claim for folic acid on dietary supplements.

It is like a Kafka novel. First, they refused our health claim outright. They said no. Second of all, they said, not only was our health claim so misleading, that there was no way it could be rendered non-misleading

through the use of a disclaimer, when the Pierson decision specifically said the FDA must allow the use of disclaimers.

So, in other words, if you said 7,000 studies seem to show increased intake of vitamin E improves your cardiovascular health, that would be a health claim. If the FDA said, that is not enough proof, they would have to let you say, this has not been proven conclusively, or, this has not been approved by the FDA. Still, the information is out there, but it doesn't have the imprimatur of the FDA.

They said there is no way we could make a health claim about folic acid, non-misleading, with a disclaimer. So we had to sue them again. Then they said, okay, but you can't say that supplements are more effective than folic acid found in foods in common form, when all the science has been done on supplements.

Then they said, all right, but you can only say up to .4 micrograms. We wanted to say .8, because .4 gives you something like 80 percent effectiveness, .8 is nearly 100 percent effective. So we thought, why not tell women .8. We are not costing them millions of

dollars here, we are talking about 12-, $15 a bottle.

The FDA fought us at every step of the way. Then they said, okay, you can use .8 micrograms, but you have to use it with a disclaimer that we write. Their disclaimer was about 150 words long and it didn't reflect the science. You couldn't fit on a bottle and it was wrong.

Finally, we won. The judge said, in her decision, that she felt that either the Agency was intentionally trying not to abide by the Pierson decision, or they were stupid.

DR. GORDON: Thank you for giving us a feeling for some of these issues. I just wanted us to get a little glimpse at the whole health issue.

Thank you all very much.

[Applause.]

DR. GORDON: Good afternoon. Nancy Haller.

MS. HALLER: Thank you for allowing me to speak today. I am with the Feldenkrais Guild of North America, and we are as diverse on this subject as there are practitioners, so I will give some viewpoints as to what might bring more consensus to our community.

There is an enormous need in our country to have a statement defining what is health. We are working to add to the burdened systems without an overall statement that gives some structure to light at the end of the tunnel. When a public statement of health is made, the programs, people, and products necessary to meet the statement to fulfill the outcomes are made available.

Language will be vital to this process and needs to be inclusive and powerful. Looking into the future and understanding it will take a century of generations to change the overall health of this nation, there is no better time to begin than now.

Once there is a statement for people to hear, see, and think about, then gradually there will be an action to meet the concepts and bring the reality to life. We all hear the statements contrary to our health in our daily lives and we have followed them. Advertising has made catch phrases that we can recite, and when it comes to the place of making choices, they ring in our heads and influence our decisions.

It is possible to use these same concepts to

the advantage of people in relationship to their health. Achieving health across the nation is a broad subject that requires allopathic, alternative, folk medicine, spirituality, environment, research, education, and cooperation. There are models where all of these have a place and are deemed appropriate and necessary.

Education and trust are paramount to begin this ongoing change in the whole structure. We need a campaign that begins in multiple directions, coming from a stated mission for health in this country. The ultimate goal is survival.

This is a long-term program that needs to be addressed. Within the structure is a place for everything that is involved in creating a healthy society. It is understandable that there would be opposition to this concept. Many huge corporations have made billions supporting our unhealthy lifestyles.

Short-term needs for health include creating the programs to fill the needs of people in prevention and care, education and accessibility to the programs by the people, trained professionals to work on many levels of care as the needs arise, and options for payments that

are affordable and will allow profits to the insurance companies.

We are headed in a direction that is appropriate, yet it seems to be scatter-shooting into the dark. There is a need for empowerment of people to trust that they are the ultimate physician, and we as practitioners are here to listen and to aid in their health decisions, offer directions for appropriate services and recovery.

As practitioners, we have the obligation to be educated, informed, cooperative, and able to hear the request and to aid the client with their choices, suggest appropriate treatments or services and products. We have the need to have insurance coding that will accurately define the work or product that is provided.

The insurance companies require that accurate billing is done, and then they are responsible to ensure that the practitioners have timely payments for services rendered. Acceptance by the public that they hold a portion of the payment responsibility, also allows them to participate more fully in the ownership of their health and well-being.

Finding appropriate avenues for ease in the acceptance of death will also be a portion of the work that is necessary for the future. The circle is possible.

DR. GORDON: Thank you.

MS. HALLER: You're welcome.

DR. GORDON: Julie Merrill.

MS. MERRILL: Good afternoon, Commissioners. My name is Julie Merrill. I am an Oriental medicine practitioner, a board member of the American Association of Oriental Medicine, and the vice president of the Maryland Oriental Medicine Association.

The AAOM is the oldest and largest national organization for acupuncture and Oriental medicine professionals. Thank you all for your hard work and for this opportunity to comment.

Let us return to the topic covered yesterday and Monday, CAM coverage and reimbursement. Do you see this New York City subway token? Do you see the hole in the middle of it? The hole in the middle of the token represents inadequate coverage. Proper coverage for services provided by properly trained practitioners can

fill that hole by providing broader access to health care that actually has the potential to provide savings to the federal government.

Federal programs and private insurance companies must reimburse for Oriental medicine's full scope of practice. Acupuncture as well as moxibustion, herbal therapy, manual therapy, nutritional counseling, et cetera, in conjunction with our diagnosis, evaluation and treatment planning at each office visit.

These treatments replace and reduce other more costly health care expenditures. This coverage should be mandated as a means to reduce the need for costlier interventions.

As for the analogy of the token, Oriental medical professionals are concerned about tokenism of various discount programs being fraudulently marketed by health plans to appear as a premium benefit. Such token attempts can be replaced by broader based health care industry mechanisms like the ABC insurance coding system developed by Alternative Link, discussed in yesterday morning's panel.

While there are currently two CPT codes for

acupuncture, a more complete coding system, such as that developed by Alternative Link, would not only aid in the equitable reimbursement of Oriental medicine and CAM services, it would also improve tracking ability and further outcome research.

Other initiatives are also underway. AAOM supports the Hinchey bill that would provide coverage of acupuncture to Medicare patients and federal employees. AAOM also supports continuation of the personal Medical Savings Account insurance option as a way to cover preventive health care services.

The hole in the center of the token also represents a gap in the logic that better-trained practitioners are paid less than those who are less trained. A practitioner with a masters or a doctorate in Oriental medicine has the ability to make an individualized differential diagnosis to more specifically and effectively treat a patient than someone who has training in a completely different form of medicine who subsequently studied Oriental medicine for 200 hours. Thank you.

DR. GORDON: Thank you.

Su Liang Ku.

MR. KU: Good afternoon, Commissioners. My name is Su Liang Ku, with the Florida Institute of Traditional Chinese Medicine. I would like to focus my testimony on traditional medicine, or TCM, particularly.

Currently, there are many patients, especially those poor senior citizens who do not have access to TCM services and products because the TCM practice and products are not covered by Medicare or their health insurance. This has greatly diminished their patient's privilege to assess TCM care and interventions to benefit their health.

In order to protect the health and well-being of our citizens and to make this form of medicine more accessible, and at the same time, to reduce overall health care expenses, additional federal and state law and policies need to be established to better recognize TCM in the following format:

Number one, TCM be recognized by federal and state laws and policies as a form of standard medical practice; (B) TCM services and products be adequately covered and reimbursed by all the federal and state

programs and private health care coverage systems; (C) all federal- and state-funded health care programs or facilities be urged to provide quality TCM services and products to all patients who seek them.

The reasoning is, number one, TCM is utilized by approximately 40 percent of the Americans, and TCM is a well established, well documented, and complete medical system that has been practiced for thousands of years on billions of patients; (B) TCM is effective, safe, and economical; (C) TCM practice is well regulated by state regulations.

The access to safe and effective TCM practice may be improved by adapting clear policies defining the qualified providers by requiring one or more of the following:

Number one, National Board or NCC certifications; (B) licensed by the State Board of Acupuncture; (C) a minimum of four academic years, with a minimum of 150 semester credit hours of training.

It is important to recognize that TCM is a complete, yet unique, medical discipline. Over 30,000 medical texts exist. This body of knowledge cannot be

learned in a couple of hundred hours, or by a non-residential training.

In the past 30 years of TCM practice in the U.S., a very few malpractice incidents of acupuncture and herbal medicine. Most were caused by practitioners other than those who have received adequate training, or who were licensed by the State Board of Acupuncture or certified by the National Board. Thank you very much.

DR. GORDON: Thank you.

Sandra Chase.

DR. CHASE: Good afternoon. I am Dr. Sandra M. Chase, the immediate past President of the American Institute of Homeopathy, the nation's oldest national medical association, and a former President of the National Center for Homeopathy, the nation's largest public organization representing the interests of classical homeopathy.

I am a family physician in the private practice in Fairfax, Virginia. I am here to share with you our concerns for reimburse, in general, and via Medicare, in particular.

Homeopathy is unique in the regulatory status

among CAM modalities. Specifically, homeopathy is included in the 1965 Medicare Act and the Homeopathic Pharmacopoeia was recognized in the 1938 Food, Drug, and Cosmetic Act. This places homeopathy drug products under ultimate regulatory authority of the FDA, which in 1988, promulgated the Compliance Policy Guide for the regulation of their marketing.

Homeopathy physician visit, which range from a few minutes for a simple acute case, up to two hours in length for a complicated chronic case, may be billed under current E&M codes, using the time component, where more than 50 percent of the visit involves consultation rather than physical examination. Codes for additional time may be added where the visit exceeds 60 minutes, or, alternatively, some physicians ask that the patient return for a second visit in order to complete the homeopathy case-taking process.

The keyword search for "homeopathy" on the website for Local Medical Review Policies, referenced by Dr. John Whyte of HCFA earlier this week, reveals that only New York policy M-95-3 bans homeopathy among other alternative medicine from Medicare coverage.

This suggests that homeopathy is covered by Medicare elsewhere in the United States. Incidentally, the language of the New York policy inaccurately describes homeopathy as including therapies using such products as antioxidants, oxidizing agents, cellular and chelation therapies, and hydrogen peroxide.

Nonetheless, physicians employing homeopathy have been harassed by HCFA in several states. The threat of that occurrence, along with the increasing complexity of E&M coding, and the potential punishments for miscoding, have caused many homeopathic physicians to opt out of Medicare participation.

The end result is limited access to homeopathic medical care among the elderly and the disabled, the very populations in which pharmaceutical costs are skyrocketing and the most potential cost savings could be achieved with medicines that cost pennies a dose.

We recommend two actions. First, a Medicare statute should be enforced as a national policy, allowing physicians to practice homeopathy without fear of reprisal throughout the 50 states.

Second, when that is accomplished, we recommend

the addition of a two-digit suffix to the E&M CPT code, indicating homeopathy has been used, by which mechanism would facilitate tracking of the utilization and cost effectiveness of homeopathic medical care throughout the health care system. Thank you.

Panel Discussion

DR. GORDON: Thank you very much.

Questions from Commissioners? I have just a couple. I want to say that I appreciate the testimony you brought. I especially appreciate Sandra Chase and Julie Merrill for picking up on our discussions, and coming back and helping us look at thing a little bit more deeply.

I wanted to ask you, Dr. Chase, about the whole issue of HCFA prosecution -- I am not sure what it is -- the adverse interactions between HCFA and homeopathic physicians. Can you tell us a little bit more about that, what happened?

DR. CHASE: Yes, sir. I can give you two specific examples. A colleague of mine in Virginia, several years ago, was told by the local oversight body that manages Medicare that they would not cover his

Medicare patients. The then president of the American Institute of Homeopathy wrote on behalf of this physician and showed the proof that homeopathy is included in the Medicare Act, and so this physicians patients were able to be covered.

However, another colleague, more recently, who is located in the State of New York, was also audited on the same level and was provided with the same information that was provided in Virginia, and the regional authority said, well, that doesn't matter; we are not going to have homeopathy covered in this area.

Additionally, I can give you the information that in my own practice, I had a patient move from my state to New Jersey, and in writing me a note, mentioned that she, who is a Medicare-eligible patient, was not able to have her homeopathic care covered now that she was living in the State of New Jersey.

DR. GORDON: Thank you.

Yes, Ming.

DR. TIAN: Since we have two experts of CAM practitioners regarding using herbs, I have a question for you. Do you have any recommendations or suggestions,

how do we ensure patient's safety, and also the benefits from the herbal remedies? And how do we regulate from the government point of view?

MS. MERRILL: Two things are happening within the Chinese herbal medical community. The American Herbal Products Association, AHPA, in conjunction with the five major Oriental medicine associations, are taking it on themselves to put together a book, a botanical safety handbook.

It is going to be three or four years in the making, where they are going to be looking at many authoritative resources regarding toxicology and other concerns, and to provide that to federal regulatory agencies to help in their decision-making process.

Also, the American Association of Oriental Medicine, I happen to be at the chair of the Herb Committee, and we are putting together an herbal safety course and manual for all students who will be graduating from school that is analogous to the current Clean Needle Technique, which is a requirement before students start their clinical rotations.

MR. KU: I would like to present this in a

different perspective. Just like the Western medicine, it has to be practiced by qualified practitioners, just like prescription drugs have to be prescribed by duly licensed practitioners. As neurological surgery, open heart surgery has to be performed by a qualified surgeon, so does Chinese medicine.

There is 100,000 items in our compendium and 100,000 formulas in the compendium. It requires a tremendous amount of study. It cannot be practiced by someone who has a few hundred hours training. The only way to secure public safety is to regulate it accordingly, to allow only the qualified practitioners who prescribe that.

Banning it is not an answer, just like you cannot ban open heart surgery because somebody died under open heart surgery. Down to the point is, who is qualified to prescribe it. That is my recommendation.

DR. GORDON: Thank you.

Wayne.

DR. JONAS: I have a question, first, to Dr. Chase, and then to Mr. Ku and Ms. Merrill, a kind of a flip-side-of-the-coin question, if you will.

What is the position of the National Center for Homeopathy on lay practitioners, and what is their role, in homeopathic practice, on non-physician or non-licensed practitioners? Are they qualified; should they be able to practice, this type of thing.

The flip side. What is the position of traditional Chinese medicine groups on M.D. practitioners from this country who do not get full training in Chinese medicine? Should they be allowed to practice; are they properly trained.

If you want to go second, or first, or whatever, it doesn't matter to me.

DR. CHASE: I am a member of the American Institute of Homeopathy and a former officer in that. I am a member of the National Center for Homeopathy. I am no longer an officer there. I really can't speak to that they have an official policy in regard to lay practice.

I am not aware that they have an official policy about it. They publish a resource guide that lists people, but I don't think they take a stand that they are advocating non-licensed people practicing.

DR. JONAS: Isn't there isn't a training

program? I know there is in England, the Society of Homeopaths, but isn't there one in the United States that is attempting to develop a fairly extensive course for training non-M.D. homeopaths?

DR. CHASE: There are a number of training programs that have come to the U.S., primarily from the United Kingdom. Again, I am not particularly familiar with the ins and outs of these organizations. They do pattern themselves after the Society of Homeopaths, where under Common Law, it is legal for them to be doing what they are doing.

In this country, the one area that I know that they have had some success in their attempts, is, I believe, in Wisconsin, where they recently got a law allowing them to practice within that state. I don't know the particulars about that.

DR. JONAS: Do you feel like there is a role for lay practitioners in this mix somewhere? Or, do you think everyone should be a fully qualified physician, licensed physician?

DR. CHASE: Which hat do you want me to wear?

DR. JONAS: Take your pick.

DR. CHASE: I think that people should be appropriately qualified in all ways to be providing health care for the public.

DR. JONAS: Dr. Ku?

MR. KU: I am not currently any officer from any national association, so I do not speak for them, but it is a general consensus in our profession, as well as I am running a school, that herbal medicine should be diagnosed by TCM practitioners.

Seventy percent of them are very neutral and very safe. They can be taken for a certain length of time by the public upon diagnosis, but one-third of them are very potent and have side effects. They cannot be taken too long.

So therefore, we do not recommend the public taking herbal medicine without any consultation to any practitioners, nor do we recommend anybody who has less than adequate training, starting to fool with this. Just as I can read a PDR, do you want me to prescribe Western medical drugs to the patients? You don't want that. That is my position.

MS. MERRILL: The physician's course is very

abbreviated. It is a 200-hour course. Sometimes they go on to do some further study, but most of the course itself is distance learning. They do learn trigger point therapy, some simple musculoskeletal treatment, and they can, sometimes be effective in the point-and-shoot variety of acupuncture.

However, they are not trained in internal medicine, in differential diagnosis, like my colleague, Dr. Ku, mentioned, nor do they know the whole field of herbal therapy, which, as Dr. Ku explained, is very intricate, very complex, very elegant, and very important to reinforce the acupuncture treatments themselves. They are often used in combination in China, and have for thousands of years. They do other adjunctive therapies, such as cupping, manual therapies, like soft tissue manipulations and guasha.

DR. JONAS: In other words, I get the sense from all of you that only fully qualified, you feel like, should be allowed to practice these therapies.

MS. MERRILL: Yes. I can speak for myself and the American Association of Oriental Medicine, that we feel that they are not qualified to practice the full

spectrum of Oriental medicine.

MR. KU: That is our general consensus, across the profession, that the recommendation for the practitioners is to adopt a national standard, which takes about four academic years and no less than 150 semester credit training, including the herbology and so forth. Those are our recommendations, and most of the state regulatory boards also adopt that policy, and that is how they are given their licensure exam standards.

DR. CHASE: Wayne, I would just like to make the point that the groups that you mentioned in regard to the North American Society of Homeopaths is a separate organization affiliated with neither the American Institute of Homeopathy, nor the National Center of Homeopathy.

DR. GORDON: Effie, do you have a question?

DR. CHOW: Yes. Building on that question, is there any attempt of communication between the lesser training and the more extensive training versus the physician and the lay homeopaths? Any comments on that? Do you feel that communication between the groups would help any?

MS. MERRILL: I don't know the full history between the two groups, but I know that there has been a lot of disagreement because the agendas are very different.

DR. GORDON: Thank you all very much. We appreciate it.

[Applause.]

MS. CHANG: Our last panelists, very, very patient. Thank you very much. Edward Owens, who is a substitute, Matt Russell, Carolyn Sabatini, Christina Walker, and Alan Dumoff.

DR. GORDON: Edward Owens, please.

DR. OWENS: Thanks for allowing me to speak today, and especially, thanks to Veronica for inviting me to come and slipping me into the schedule. I am going to go ahead and read my talk.

I am here to discuss some of the challenges we face in the chiropractic research community, and reiterate what some of the other speakers for chiropractic have said. I am the research director at Sherman College of Straight Chiropractic in Spartanberg, South Carolina. I have been involved in chiropractic as

an educator, a research, and practitioner for almost 20 years.

My boss, Dr. Brian McAuley, spoke here on February 23rd, and he raised some very important points. He was speaking for chiropractic, but really CAM in general. First, there is a huge disparity between the research funding to medical schools and that to alternative schools.

The NIH alone granted some $6.5 billion to the top 50 medical schools in 1999. However, the entire budget for the NCCAM, which funds most of the CAM research, which is the federal funding arm for CAM research, is on the order of $70 million, only about 1 percent of the NIH budget.

The chiropractic groups draw from the CCR, which is funded by the NCCAM, and they have funded about $250,000 of research in the last four years. We need to formally recognize the value and appropriateness of the meta-therapeutic health care paradigm that focuses on enhancing performance and function, rather than treating disease, at the risk of making you all complemental.

This would put more emphasis on the

complementary in CAM, and recognize there is a fundamental difference in the approaches between allopathic care and complementary care. Complementary care is more often aimed at improving the health of the whole person, rather than treating a particular symptom. You might even have people going to a complementary practitioner, even if they feel well. They want to prevent any kind of illness in the future.

Point three. More federal funding should be directed to research efforts in the wellness and preventive health paradigm that explores ways to help people avoid serious health problems and enjoy greater function and performance. This emphasis is a natural outgrowth of an increased awareness of the potential of meta-therapeutic methods to help forestall disease.

Drs. Tony Rosner and Bill Meeker spoke here. They are both chiropractic researchers. Some of their points were aimed at helping to solve, to reach some of the goals that Dr. McAuley raised. Dr. Rosner again brought up the idea of preventive aspect of chiropractic care, particularly the effects of long-term care.

We won't really have RCTs that can demonstrate

effects of long-term care. We have to have different types of studies. An emphasis on randomized, clinical trials to test the efficacy of any therapy on a particular condition would not be effective in supporting or refuting the preventive benefits of long-term care. We need to relax the dependence on RCTs, and perhaps open research funds to long-terms descriptive studies such as cohort designs and case series.

We tried to do some of this at Sherman College, and we found that federal funding on this kind of research is very difficult to obtain, even through our own consortial Center for Chiropractic Research. Dr. Rosner suggested that we could provide better balanced and enlightened study sections to review grant applications throughout the NIH, but we could also apply that through the CCCR. Thank you very much.

DR. GORDON: Thank you.

Matt Russell.

MR. RUSSELL: Chairman Gordon and remaining Members of the Commission, good afternoon. My name is Matt Russell. I am the executive director of the National Integrative Medicine Council.

There are many important issues about which I could testify today. As you know, just a little over a week ago, the Integrative Medicine/Industry Leadership Summit convened in Arizona to address issues concerning reimbursements, clinics, employer strategies, CAM integration, and national policy.

It was very heartening for me to see such positive communications across stakeholder lines. While we honor all the good work coming out of this summit, and expect to play an integral role in advancing issues of importance to the CAM professions, my testimony today focuses on specific public policy recommendations for physician education. This is an area where we believe an immediate opportunity exists.

Not surprisingly, the current structure of education and training of physicians in this country is inadequately preparing our physician workforce to meet the needs of patients. I believe it was Hippocrates who is often quoted as saying, "Cure sometimes, heal often, comfort always."

Unfortunately, today's physicians are encouraged to cure always, heal if they have the time,

and leave the comforting to someone else. Physicians are entering practice with frustrations about not being able to spend more than just a few minute with their patients and are forced to rely too heavily on costly and impersonal technologies.

Ironically, the shift toward high tech medicine over the past few decades is a dramatic departure from what our patients are saying, loud and clear, is important to them. Patients are looking for doctors who are sensitive about complementary and alternative therapies, and can knowledgeably guide their patients through the confusing maze of treatment options.

So what, then, can be done to respond to this appeal for a healing-oriented health care system without neglecting the significant role that conventional medicine plays. There have been many, many solutions proposed. We have heard that our case needs to be made to the insurance industry, once issues of cost effectiveness and quality can be ascertained.

We have heard that the case needs to be made to employers that if our nation's workforce unites behind this message, then third party payers will respond. We

have heard that the solution lies in more appropriate moving away from the RCT, and toward a clinical outcomes research. We have heard the consumer and health care providers alike need access to reliable information about choices in health care.

These are all very important issues, each playing a significant role. However, if we do not have an adequately trained and educated physician workforce, then our model system is still threatened.

It is ambitious, if not unrealistic, to assume that we can realize the kinds of shifts in medical education that we believe is important over the short term. However, with only a few years, we can begin to see the initial effects of this model.

Here are my recommendations. The National Integrative Medicine Council is advocating for a small federal demonstration program to gauge the effectiveness of building pre-doctoral medical educational around an integrative model.

The concept of providing grants to medical schools to evaluate new innovations in education is not new. Launched in 1997, under the Health Resources and

Services Administration, HRSA, the federal UME-21 program, which is Undergraduate Medical Education for the 21st century, has already awarded 18 grants to 18 medical schools, each of which have proposed certain curriculum innovations.

We believe a similar system can be created for medical schools to build integrative curricula. The funding for medical schools for this purpose is critical, and we urge the Commission to make recommendations for HRSA to set aside specific monies to encourage medical schools to train medical students in integrative curricula.

DR. GORDON: Thank you, and thank you for focusing on a specific recommendation. We appreciate that.

Carolyn Sabatini.

MS. SABATINI: Hello, Commissioners. Thank you for this opportunity to speak. I am the government and regulatory affairs manager at Pharmavite Corporation. Pharmavite manufactures dietary supplements and markets these products under the Nature Made and Nature's Resource brand names.

Since 1971, Pharmavite has been committed to providing consumers with quality dietary supplements to make a positive impact in people's lives. We are pleased to offer suggestions on the dissemination of reliable information on CAM to health care providers and the general public.

I will share with the Commission some of Pharmavite's routine information-sharing practices. We encourage other dietary supplement manufacturers to continue or adopt similar communication approaches because information exchange benefits everyone.

Pharmavite regularly shares reliable information on its products with health care providers. We employ a team of registered dieticians, traveling the country giving accredited continuing education courses for pharmacists, as well as science-based lectures on dietary supplements to other health care providers, professional associations, and interested consumer groups.

We developed a comprehensive, heavily referenced product manual that outlines usage, recommended dosage, safety, side effects, and adverse

reactions, if any, with conventional medicines. We call it our vitamin and herb university, are pleased that the Purdue School of Pharmacy includes this manual as part of its curriculum.

We have also distributed this manual to retail pharmacists, nutritionists, and others nationwide. We also operate several toll free information lines for trained professionals, as well as the general public, to address any questions about product safety, usage and stated benefits, and clearly note warnings on our product labels, if needed, and identify those groups of consumers, such as pregnant women and those currently taking prescription medication who should consult with a health care provider before taking our products.

In addition, our website contain detailed product information, suggested dosage, drug/nutrient interactions, and an information forum we call "Ask Our Nutritionist."

However, I would like to address one additional subject. That is objects and barrier, and possible solutions to accomplishing this goal. One obstacle that we face in the industry is the inability to effectively

communicate product quality to the public.

While Pharmavite and other dietary supplement manufacturers follow strict quality assurance programs, the public and media perceive that we are not regulated. This misperception may in part exist because FDA has not fulfilled the Dietary Supplement Health and Education Act.

Pharmavite has supported and endorsed, and long awaited formal GMPs to compliment our own efforts to build public confidence in the quality and safety of our products. We believe the Office of Management and Budget has an obligation to give FDA the ability to set the GMPs that we have been waiting for for seven years. Our industry's ability to disseminate reliable information would be improved if people had a better understanding of how closely we are regulated.

In addition, I would just like to make note that is not in my comments, that in meeting today with Senator Harkin's office, they will be submitting legislation to amend the tax code to include dietary supplements as a deductible medical expense. Thank you very much.

DR. GORDON: Thank you, and thanks for clarifying.

Christina Walker.

MS. WALKER: Thank you, Dr. Gordon, Commissioners and staff. I am a nurse and I am Director of the Shenk Human Energetic Institute. In this testimony, I will present a case study and interweave recommendations concerning research.

A 19-year old female victim of a car accident is in a coma for 10 days, experiences multiple fractures, hypovolemic shock, right pneumothorax, and a near-death experience. It takes one year to heal her physical symptoms. For the next 25 years, she becomes a chronic pain patient. She goes from physician to physician who cannot find a reason, physically, for her pain.

On her journey, she comes into touch with alternative medicine. She starts with acupuncture and the pain starts to reduce, but she is told she is unable to hold the treatments. She begins her studies in healing touch to study the chakra system, for she knows her pain lies somewhere energetically.

She begins to explore her consciousness to make

sense of many different frequency bands she experienced during her near-death experience. Through this search of her consciousness, she finds she still disassociates and has not fully reentered her physical body from the trauma she experienced so long ago. With this realization, she understands, how could any energetic treatment give her the full results.

Recommendation. During research, we need to get a sense of where is the person's energy body. For example, the person may say, I am beside myself, which means the energy body is next to the physical body.

This may effect results if you mix population types because the treatment is different. With this knowledge she has now acquired, she enters a state of prayer to find someone who can teach her how to reenter her physical body. This search leads her to Austria with the teacher, Christine Shenk.

During the course of her studies with Christine Shenk, she is taught and experiences that some parts of the energy system are closer to the physical body, and others are farther away. So, which space are we really researching? What levels of space are you studying in

the energy body, for each space has to be studied differently?

Recommendations. You need to know where you are according to the energy body anatomy. The patient learns to reenter the body, make peace within herself and to start to feel the regeneration of her energy system, with Christine Shenk's energy trainings.

Now grounded and clear, she finds out her entire energy system was smashed in the car accident, which explains why she was disassociated, in chronic pain, and energetically unable to hold any form of alternative treatment. With this information, she realized she needed to take a closer look at selection criteria.

Recommendations. Researchers need to understand the energy anatomy in a more comprehensive way. They need to see the big picture, not just the small area they work in, because that small area affects the entire energy system. The client I present to you today is me. I give much more in-depth recommendations in the paper attached.

Research is based on science, and the

perception of the energy body is based on feelings. Therefore, our study designs need to be different. Sometimes we are chosen to walk this journey personally and experience research from that place, which yields a different knowing.

DR. GORDON: Thank you. Thanks for the additional testimony you provided for us as well.

Alan Dumoff.

MR. DUMOFF: Thank you, Dr. Gordon. Thank you, Members of the Commission and staff. I am an attorney who has been practicing for 13 years, specializing that entire in the legal and other issues regarding the practice of complementary and alternative medicine and this integration. I would like to share, just briefly, five points of concern to focus the attention of the Commission on some recommendations regarding reimbursement policy.

The first of these has to do with medical necessity and standards of care in reimbursement decisions. As I know the Commission is aware, often when insurance companies deny coverage for CAM practices, particularly with physicians, their stated basis for

rejection is that they are not medically necessary.

What I would like to also focus the attention of the Commission on, though, is that this rubric is often used beyond that to actually, in some way, harass physicians who practice alternative medicine.

In one case I was involved in with a well known alternative cancer therapist/physician in San Diego, Medicare actually moved to exclude a physician from participating in Medicare, because in their view, non-standard medical practice is, by definition, substandard medicine, and that legal issue really goes to the crux of many of the difficulties that we face in this field.

In another situation, a physician I currently represent in Maryland, he got brought before the Board because Blue Cross, who was concerned about the innovative practices he was providing, complained to the Medical Board, even though he was not submitting bills for what he knew were non-covered services. So even if you try to practice legally and bill properly, you can still get in trouble because of differences of professional judgement.

So I think it is imperative that the Commission

look at medical necessity and standards of care, and the way they operate across the board in terms of medical reimbursement, and also, the way medical boards interpret private practice.

E&M coding, the Board has heard a lot about that. It is very difficult for holistic physicians who spend much time with patients to properly bill. I would simply urge that the Commission consider some communication directly with the AMA, HCFA committee that works on documentation and billing guidelines.

A third issues is Medicare same-day rule, where if you go see a physician in a practice for low-back pain in an integrative practice, and then go see the chiropractor the same day, you can't get covered for the chiropractor. It makes team practice very difficult.

Fourthly, incident to billing is an issue I have raised with the Commission in an open letter I had published. I would just take this moment to highlight the issue. It is one where upcoming changes could make it more difficult for nutritionists and other practitioners to bill under a physician.

Fifthly, getting good information is very

difficult. I go into a lot of practices, integrative practices, and the wealth of details that are involved in properly coding are very difficult for folks to understand. Some kind of a clearinghouse would help. Thank you.

Panel Discussion

DR. GORDON: Thank you, and also thank you for the articles that you have written on the subject.

Questions from the Commissioners? Veronica.

DR. GUTIERREZ: I have had several conversations. This is in regards to chiropractic research. We have 17 colleges, we have a consortium for chiropractic research, which has only five members. So far, all the research dollars have been directed directly to this group, and I understand some of that is because of the familiarity of dealing with the same people over and over again.

I know there has been a barrier to your college as well as others, and I would like you to tell us if there have been any other barriers that you have run into in your efforts to get research dollars.

DR. OWENS: That is one of the major ones,

because that is our major key into NCCAM funding. So going through the CCCR is our major route there. Most of the problem is inexperience with the federal forms. That is probably part of it. We don't have good representation in the review boards of the CCCR. It is mostly controlled by those five colleges, so we don't have a lot of representation.

Our methods, the straight chiropractic-, the subluxation-centered care is a little different than the musculoskeletal methods. The musculoskeletal methods are getting more of the research funding, and the subluxation-centered does not.

DR. GORDON: Other questions? Effie, go ahead.

DR. CHOW: Again, regarding chiropractic. What is straight chiropractic?

DR. OWENS: It is the same as being subluxation-centered. It is providing wellness care, it is providing maintenance care that is not directed at illnesses, but more directed at enhancing function. So it is investigating the spine, looking for aberrancies in the spine and adjusting those, whether the patient is expressing symptoms or not.

DR. GORDON: Other questions? Wayne, go ahead.

DR. JONAS: I had one question to Ms. Sabatini. I saw the toll free number in here. Is it possible to get this report, or is it possible to look at it on the website, what you are describing? I only have one page in here. I don't know if there is another one somewhere else. Is it possible to get more information about this?

MS. SABATINI: About the company?

DR. JONAS: Well, no, about this --

MS. SABATINI: Oh, the Vitamin and Herb University?

DR. JONAS: Yes.

MS. SABATINI: Yes, it is. I can provide that. It is not on the website. We have 12 CE programs that are certified for pharmacists that are on our website that are accessible by a code given to pharmacists, so that the general public don't access them.

DR. JONAS: Pharmacists can get CE credit for this?

MS. SABATINI: Yes.

DR. JONAS: I had also one question for Matt

Russell.

Now, HRSA, is there any exclusion in terms of applying for some of these training grants in HRSA right now? Is it possible for complementary medicine groups to apply, or for medical schools to apply?

MR. RUSSELL: Right, the UME-21 program?

DR. JONAS: Yes.

MR. RUSSELL: It is my understanding that that is only for schools of medicine and schools of osteopathy, and it is directed just on medical schools. However, there still could be some opportunities in my written testimony, and the timing of this, Dr. Jonas, is ideal. Congress is expected to reauthorize the Public Health Service Act, and the specific titles that fund health professions this year.

So I talk in my written testimony that this is the ideal framework if we are looking at strategic ways to support and invest in health professions education, and I mean osteopathic, allopathic, as well as the CAM profession schools. This is the right time to do it to be a part of that conversation.

DR. GORDON: Following up on that, are there

integrative medicine programs at medical schools or osteopathic schools that are being under this act now?

MR. RUSSELL: There are not integrative medicine programs being funded under UME-21. They are all about curriculum innovations, but none of them, to date, have been to support a specific integrative curriculum.

DR. GORDON: If you would, since you have done this homework, could you send us the information from the bill and what you would suggest the kinds of recommendations we might make about it.

MR. RUSSELL: Absolutely, yes.

DR. GORDON: That would be very helpful.

MR. RUSSELL: I would be glad to.

DR. GORDON: Alan, I appreciate this, perhaps the complexity of this issue related to HCFA, but anything you could do in terms of making it easier for us to understand the issues. If the articles have explicated it all, that is fine. If there is anything you could send us that would help us understand that, because obviously our whole concern, or the concern of the day and a half of these hearings, has been related to

financing and reimbursement.

So we would very much like to have your thoughts, both about what the issues are and what kind of clarification would be called for.

MR. DUMOFF: I would certainly be happy to provide some more detailed information for the Commission.

DR. GORDON: That would be great.

MR. RUSSELL: Ironically, the nominee for the new HCFA administrator just had his confirmation hearings this afternoon on the Hill, so now is a very good time for the community to begin its education of Mr. Tom Scully, who is the heir-apparent to be the new HCFA administrator.

DR. GORDON: Great. Other questions from any of the Commissioners?

[No response.]

DR. GORDON: Thank you all very much, and thank you all in the audience for being with us. Goodnight. Thank you.

[Applause.]

[Whereupon, at 5:51 p.m., the meeting was

concluded.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE THE: White House Commission on Complementary and Alternative Medicine

HELD: May 14-16, 2001

were convened as herein appears, and that this is the official transcript thereof for the file of the Department or Commission.

SONIA GONZALEZ, Court Reporter