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White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

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FOLDER TITLE:
WHCCAMP, December 6-7, 2001 [2]

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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Proposed Recommendations (As of 11/16/01 @ 4:25pm)

Coordination of Complementary and Alternative Medicine Research

1. The Commission recommends strengthening the emerging dialogue between conventional medicine and CAM by continuing to develop ways to enhance communication, cooperation, and collaboration among conventional and CAM research and clinical professionals, research centers and accredited institutions, professional organizations, and Federal and state research and health agencies, the private and nonprofit sectors, and the general public.

2. The Commission recommends that standards of quality for all aspects of research and related activities be the same for CAM as for conventional medicine.

3. The Commission recommends that research, journal, regulatory, and health insurance advisory and review committees in both the public and private sectors include, as needed, trained and qualified CAM and conventional professionals, and recommends adapting as appropriate, any regulations that might impede such representation.

4. The Commission recommends independent or collaborative support by the public, private, and nonprofit sectors to organize multidisciplinary conferences on CAM research to increase opportunities for CAM and conventional medical practitioners, clinicians, researchers and others to exchange ideas on approaches to studying and supporting CAM research.

5. The Commission encourages the creation of novel funding partnerships or consortia within the nonprofit sector and the private sector to augment, collaboratively with Federal agencies or separately, support for CAM research, research infrastructure and training, research conferences, and information dissemination.

6. The Commission recommends supporting research on why people use CAM, how they determine its effectiveness, and what they find satisfying about CAM itself and in comparison with conventional medicine, and parallel this research with the public impact on the emerging integrated healthcare system.

7. The Commission recommends that Federal agencies supporting biomedical and health services research develop training programs for public representatives to help them provide their input in the most effective way with respect to biomedical and health services research agendas and budget policy, and the dissemination of information.

8. The Commission recommends that all Federal agencies with research or related health care responsibilities increase CAM activities relevant to their biomedical or health services missions in a more proactive manner, including the consideration of special initiatives, to ensure that CAM is properly integrated into the health care system..

9. The Commission recommends that state professional regulatory boards develop processes that will allow practitioners who have developed scientifically acceptable preliminary data to move successfully to clinical investigation of a non-approved treatment while maintaining their

ethical and professional responsibilities toward their patients and the public.

10. The Commission recommends that NIH Institutes and Centers and other Federal agencies, as appropriate, develop programs to evaluate practice-based data for potential research support, communicate the availability of such initiatives in a proactive manner to CAM and conventionally-trained practitioners who believe they have promising data on non-approved treatments, and provide training in data collection, protocol development, and ethical guidelines and human subject protection.

11. The Commission recommends continuing adequate public funding for research on promising and/or frequently used CAM products that would be unlikely to receive a patent and therefore not likely to attract private research dollars.

12. The Commission recommends that the Federal government provide incentives to stimulate private sector investment in research on CAM products and NDA development, and on developing analytical methods for producing better quality CAM products.

13. The Commission recommends that the Federal and private sectors provide support for workshops to discuss research needs for regulatory review and approval of CAM products and devices.

14. The Commission recommends Federal, private, and nonprofit support for new, innovative and sometimes controversial CAM research in emerging areas of scientific study that might expand our understanding of health and disease and encourages support for basic research on core questions described in many CAM systems.

15. The Commission recommends that NCCAM conduct a review assisted by the National Science Foundation, the Institute of Medicine, the World Health Organization, or other Federal or non-Federal bodies on methods to study in a credible manner, emerging areas of scientific investigation associated with CAM.

16. The Commission recommends providing increased public and private resources to strengthen the CAM research infrastructure at strategically located conventional medical and CAM sites to expand the core of researchers knowledgeable about CAM, who have received rigorous research training in basic, clinical, and health services research.

17. The Commission recommends strong support for enhanced research training by all Federal health agencies with research training programs and responsibilities that encompass CAM-related questions.

18. The Commission recommends utilizing existing resources, such as NCCAM-supported centers and the National Center for Research Resources' General Clinical Research Centers to increase opportunities to conduct clinical research and training on CAM and examine the integration of CAM into the clinical setting.

19. The Commission recommends continued strong support for career development awards

that enable investigators focusing on CAM to develop into independent investigators and faculty members, and mid-career awards to provide the time required to mentor new CAM investigators.

20. The Commission recommends that public and private resources support, conduct, and update systematic reviews of current evidence in the research literature on the safety (including contraindications) and efficacy of CAM practices and products. These reviews should be written in understandable English and other languages, and should be easily obtained from multiple publicly available information services, including the National Library of Medicine's MedlinePlus database, which is accessible directly and through public libraries.

21. The Commission recommends that the Agency for Healthcare Research and Quality expand its Evidence-based Practice Center systematic reviews on CAM treatments for use by private and public entities in developing tools, such as practice guidelines, performance measures, and review criteria.

22. The Commission recommends that a summary report of current clinical evidence on CAM be produced and updated at appropriate intervals.

CAM Information Development and Dissemination

23. The Commission recommends that the Secretary, DHHS, establish an inter-departmental task force to identify and eliminate existing gaps in the development and dissemination CAM information in the Federal government, and that increased resources be provided to centralize CAM information for the public and the media. This should include a toll-free telephone number that directs callers to the appropriate department, agency, and/or person for specific CAM information.

24. The Commission recommends that resources be made available to a) develop CAM informational materials at a level that most of the adult general public can understand and utilize; and b) support national and local community leaders and organizations in identifying strategies and developing materials to enhance the availability of CAM information to the communities they represent and help prevent special populations from being targeted for products or services that are unnecessary, harmful, exorbitantly priced, or otherwise detrimental.

25. The Commission recommends that current efforts of the National Library of Medicine and the American Library Association to develop training materials and provide training to librarians in guiding people to find health information be expanded to include CAM information.

26. The Commission recommends that the Secretary, DHHS, form a public-private partnership to review new and existing websites and develop voluntary standards that will promote accuracy, fairness, comprehensiveness, and timeliness of information on CAM internet sites, as well as disclosure of sources of support and any conflicts of interest. Sites reviewed and found in compliance with the standards could publicize this achievement and display a logo identified with this level of merit.

27. The Commission recommends that funding be provided to the Secretaries, DHHS and

Department of Education, to jointly conduct a public education campaign that teaches people, including students, how to evaluate health care information, including CAM information, particularly on the internet.

28. The Commission recommends that Congress protect the privacy of individuals using CAM internet sites by a) requiring all health information sites, including CAM sites, to disclose if users are tracked and how that information is utilized (including whether that information is sold to third parties), and stored; and b) expanding existing legislation or regulations to assure that the privacy of CAM health information seekers on the internet is protected.

29. The Commission recommends that barriers to identifying and translating relevant articles, reports, and other materials be identified; strategies be developed to overcome these barriers; and that relevant and high quality, scientific materials are made available to researchers, clinicians, policymakers, and others.

30. The Commission recommends that States and local governments require all persons providing any kind of health services or products, including CAM, to make information easily available to consumers that explains their level and scope of training so that consumers can make informed choices. [Note: This may be moved to the access section]

31. The Commission recommends that States and local governments make information on state guidelines, requirements, licensure, certification, and disciplinary actions of health providers, including CAM providers, readily available to the public.

32. The Commission recommends that additional support be provided to the Federal Trade Commission to a)expand efforts to identify false and deceptive CAM- related health claims and take appropriate enforcement action; and b)increase consumer education in identifying deceptive and unsubstantiated claims in all forms of marketing and advertising.

33. The Commission recommends that efforts of both the public and private sectors to assure the development, validation, and dissemination of analytical methods and reference materials for well-characterized dietary supplements to the public be enhanced and accelerated.

34. The Commission recommends that the Good Manufacturing Practices for Dietary Supplements be implemented to help assure the quality and composition of dietary supplements, and that a study be commenced 12 - 18 months after the full implementation of the GMPs by an external organization to evaluate current efforts and provide recommendations for improvement.

35. The Commission recommends that appropriate Federal entities work with manufacturers and importers to monitor the quality of imported and domestic dietary supplements to identify and prevent products that are contaminated or adulterated from entering the US marketplace.

36. The Commission recommends that DHHS and other appropriate Federal Departments and Agencies work with the Codex Alimentarius Commission, World Health Organization, Agency for International Development, and other international organizations to establish standards to help assure the quality of imported dietary supplements and prevent products that

are contaminated or adulterated from entering the US marketplace.

37. The Commission recommends that information on benefits, appropriate use, and potential risks be made more easily available at the time of purchase through improved labeling, package inserts, and information at points-of-sale. When significant interactions with prescription or OTC drugs, foods, or other health products are known, this information should be on the label. In addition, labels or information provided to consumers should identify possible risks to vulnerable populations such as children, the elderly, pregnant or nursing women, and those with certain health conditions or compromised immune systems. All information on labels should be in English, even if another language is also included.

38. The Commission recommends that the FDA develop guidelines to assist the dietary supplement industry in understanding and complying with the FFDCA sections of 201(n) and 403(a)(1) which require that material facts be included on labels of all products regulated by the FDA.

39. The Commission recommends that the FDA and other agencies with regulatory responsibilities be provided with the necessary funds to employ additional professionals with expertise in dietary supplements.

40. The Commission recommends that Congress require dietary supplement manufacturers and suppliers to register their products with the FDA and that the FDA encourage voluntary registration until such a requirement is in effect. This information is for the purpose of notifying manufacturers and suppliers in the event that a problem is identified with a product.

41. The Commission recommends that dietary supplement manufacturers and suppliers be required to maintain a record of adverse events and report serious adverse events to the FDA to facilitate FDA's dissemination of information to other manufacturers and suppliers and the public, and that the FDA promptly notify manufacturers of any severe and/or clinically significant adverse events reported to the FDA to allow companies the opportunity to provide important information about known safety and product formulation

42. The Commission recommends that additional resources and support be provided to the FDA to simplify the Adverse Event Reporting system and increase outreach activities to health professionals (including poison control centers, emergency room physicians, CAM practitioners, mid-level marketers) and consumers to underscore the importance of reporting adverse events.

Education and Training of Health Care Practitioners in Cam

43. The Commission recommends that appropriate support should be made available through competitive award processes for CAM faculty, curricula, and program development at accredited CAM and conventional institutions.

44. The Commission recommends that joint research, education and training programs involving CAM and conventional institutions should be supported to focus research on clinically

relevant topics, improve the quality of research conducted, and link research with evidenced-based education and training.

45. The Commission recommends that conferences should be convened by the proposed Federal CAM Coordinating Office to assemble the leadership of professions, educational institutions, and appropriate organizations to determine the feasibility of and possible mechanisms for establishing national CAM education and training standards.

46. The Commission recommends that all CAM and conventional education and training programs should develop curricula and other methods to facilitate communication and foster collaboration between CAM and conventional students, practitioners, researchers, educators, institutions and organizations.

47. The Commission recommends that core elements of a biomedical science and conventional health care curriculum for CAM education and training programs should be determined along with methods for incorporation into existing curricula through demonstration projects and conferences with subsequent results, models, and recommendations compiled and available on the internet.

48. The Commission recommends that traditional healers should be educated and trained in accordance with their respective established traditions to ensure that culturally appropriate access to traditional healers and healing is maintained.

49. The Commission recommends that demonstration projects should be developed to determine the feasibility of expanding the role of appropriately trained CAM practitioners becoming primary care providers, so that the eligibility of CAM students to participate in existing loan and scholarship programs and CAM practitioners to participate in loan forgiveness programs can be evaluated.

50. The Commission recommends that a core curriculum of knowledge about CAM systems, modalities, therapies, approaches, fundamentals, and principles should be developed in conjunction with CAM experts and CAM institutions, based on minimal knowledge-related competencies, and designed with maximal latitude for easy and cost-effective implementation at conventional health professional schools, in postgraduate training programs, and in continuing education programs to increase knowledge and understanding of CAM, so that conventional health professionals can discuss and provide guidance for the appropriate use of CAM.

51. The Commission recommends that demonstration projects of joint primary care residencies for appropriately educated and trained CAM practitioners and conventional physicians should be conducted to determine the feasibility of such residencies and their impact on collaboration, clinical competency, and quality of health care.

Access and Delivery of CAM

52. No later than 6 months following the receipt of the White House Commission on Complementary and Alternative Medicine Policy's report, the Secretary of Health and Human

Services should establish a national policy advisory board that will support and coordinate efforts with a designated Federal office for CAM to develop policy guidelines on issues related to the access and delivery of CAM.

53. Within 18 months of being established, the national policy advisory board appointed by Health and Human Services (HHS) will research, develop and publish a set of national standards for the practice of CAM. These standards will establish minimum educational, ethical and practice guidelines for any practitioner wishing to provide health care via CAM approaches, and focus on ensuring patients with necessary safeguards.

54. With guidance from the HHS' national advisory board on CAM policy, the designated Federal office for CAM should actively promote the development of consensus and practice standards that are specific to a wide variety of CAM practices.

55. With the support and facilitative efforts of the designated Federal office for CAM, CAM practices and professions should establish a single, voluntary, national organization to register, regulate, and represent its members.

56. States strongly are encouraged to use and implement the national practice standards developed by the HHS's advisory board, and to acknowledge and recognize the self-regulating authority of single, national, voluntary CAM organizations by requiring that CAM practitioners be registered through such organizations, and by providing broad legal authority and limited uniform protection for CAM practitioners who qualify under the national practice standards and who register with a self-regulating organization.

57. Within18 months of being established, the HHS' national policy advisory board should begin a process to develop national uniform scopes of practice for CAM practices, primarily to address those practices deemed to present the most potential risks to patients. States are encouraged to use these scopes of practice to provide the necessary legal authority and licensure of such practitioners.

58. State medical boards strongly are encouraged to work closely with HHS' advisory board through the designated Federal office for CAM to develop standard operational guidelines for the regulation and oversight of licensed physicians practicing CAM, which are based on national uniform scopes of practices developed by the HHS board.

59. The Commission recommends that nationally recognized accrediting bodies assume leadership roles to review the most commonly used and evidence-based CAM modalities, especially those with particular relevance to a coordinated care approach, with respect to establishing accreditation standards.

60. The Federal Government, including but not limited to HHS, should fund and support efforts by the designated Federal office on CAM to coordinate detailed and expanded epidemiologic surveys of CAM patterns of use, with special attention to ethnic and vulnerable populations.

61. The Federal Government, including but not limited to HHS, should fund and support efforts by the designated Federal office on CAM to collaborate with private sector studies and demonstration projects that evaluate the usefulness, effectiveness and cost-benefits of collaborative care models at three delivery levels: global health care systems, such as hospitals, community health centers, and managed care settings; specialized health care systems, such as hospice care; and small clinical settings, such as individual and group practices.

62. Based on studies and demonstration projects evaluating the effectiveness and cost benefits of collaborative care models at three delivery levels, the Federal Government, including but not limited to HHS, should fund and support efforts by the designated Federal office for CAM to convene strategic planning conferences addressing the needs of seriously ill and dying patients, as well as other special populations, to determine best practice guidelines that incorporate conventional palliative care with appropriate and effective CAM approaches.

63. Within 3 years of being established, the designated Federal office for CAM shall report to the Secretary of HHS on the use of indigenous healing traditions in the United States to identify common use, best practices, and challenges and potential areas for collaborative learning between such traditions and conventional care. The Commission urges this report to include recommendations for the future as regards appropriate protection of such traditions, as well as research and development of such practices as part of community-based health care. Members from such traditions should be involved closely in this endeavor.

64. The Federal Government, including but not limited to the Department of Agriculture and HHS, should fund and support efforts by the designated Federal office on CAM to evaluate the feasibility, costs vs benefits, and overall impact on allowing Food Stamp Program Participants to use food stamps to purchase specified single or multiple vitamin-mineral products that do not exceed the nutrient recommendations of the Food and Nutrition Board of the Institute of Medicine.

Coverage and Reimbursement

65. The Commission recommends that purchasers and other health plan sponsors, insurance companies and managed care organizations offer coverage of safe and effective CAM interventions in a manner and through a process equivalent to that used for conventional medicine.

66. The Commission recommends that purchasers and other health plan sponsors, insurance companies, managed care organizations, and health care organizations which influence health policy and interventions open their processes to CAM, such as maintaining an expertise regarding CAM and including CAM experts on appropriate advisory bodies and working groups related to health benefits plans, health care coverage, reimbursement, and applicable processes including coding.

67. The Commission recommends that professionals working in complementary and alternative health care actively seek opportunities to advise and participate on public and private bodies that address issues related to health services research (for CAM or, where appropriate,

health care generally), CAM-related demonstration projects, coverage and payment for health services and products, and improvements to coverage-related processes, such as coding.

68. The Commission recommends the Secretary, Department of Health and Human Services (DHHS), convene a public and private task force to develop a multiyear health services research plan that identifies and addresses CAM research and demonstration questions, methodologies, data, priorities, and coordination. The task force should convene within 3 months of its appointment, and submit its report to the Secretary within 18 months of its appointment.

69. The Commission recommends that Federal agencies, states, and private organizations fund health services research and demonstrations on the safety and clinical effectiveness of CAM practices and products, the use of CAM in underserved and vulnerable populations, and the efficacy of various models for providing CAM services, including integration and collaboration, within the U.S. health care system.

70. The Commission recommends that Federal agencies, state, and private organizations fund health services research and demonstrations on the costs and cost-effectiveness of CAM interventions and wellness programs.

71. The Commission recommends that the Secretary, Department of Health and Human Services, support the development of coding for CAM services and products and, specifically, conduct a study analyzing nationally-used coding systems (including current CAM systems) and the issues associated with integrated versus separate CAM coding systems, and make recommendations.

72. The Commission recommends that state governments recognize and address barriers to third-party coverage of safe and effective CAM services related to the legal authority to practice CAM interventions within the state.

73. The Commission recommends the Secretary, Department of Health and Human Services, through the National Institutes of Health and other appropriate agencies, identify CAM interventions of importance to patients, health care providers, and the general public that need an assessment of the state-of-the-science, and conduct conferences to produce consensus statements.

74. The Commission recommends that the National Center for Complementary and Alternative Medicine, through its clearinghouse, provide information on safe and effective CAM services and products including information on health services research and demonstrations, models of providing CAM, costs and cost-effectiveness.

75. The Commission recommends that appropriate Federal departments report to the President and Congress on the status, coverage and reimbursement, and impediments to coverage and reimbursement of CAM services and products for their respective beneficiaries or through their respective sponsorships.

76. The Commission recommends that health care entities that influence health policy and the delivery of health care services, such as insurance and managed care associations, integrate information regarding safe and effective CAM interventions into appropriate professional

meetings.

77. The Commission recommends that the Secretary, Department of Health and Human Services, provide support for the development of informational programs on safe and effective CAM services and products which are targeted to purchasers, insurers managed care organizations, health care professionals, and providers of health care services.

Cam in Wellness, Self-care and Prevention

78. The Commission recommends that DHHS review the 10 leading health indicators[1] and, where appropriate, develop strategies to encourage the use of safe and effective CAM principles and practices in these areas.

79. The Commission recommends that questions on specific CAM usage be included in the national surveys that are the sources of the HP 2010 data including the National Health Interview Survey, National Health and Nutrition Examination Survey, and the Medical Expenditure Panel Survey.

80. The Commission recommends that CAM become part of a national focus to improve the health behaviors of children. Where appropriate, CAM practices should be incorporated into national guidelines on wellness and prevention practices for children, and a media campaign be should be conducted that includes public service announcements and involvement of public figures to teach and encourage healthy behaviors among children

81. The Commission recommends that, in partnership with the business community and school boards, incentives be developed for schools to make available healthier school lunches and snacks and to limit the sale and advertising of high fat snacks, soft drinks, and other products that do not contribute to a healthy lifestyle.

82. The Commission recommends that CAM wellness and prevention activities be included in all Federal worksite wellness and health promotion programs and Federal health coverage plans.

83. The Commission recommends that, in consultation with the business community, incentives be developed for employers to include CAM wellness and prevention in worksite wellness programs and health coverage and decrease premiums.

84. The Commission recommends that the Secretary, DHHS, establish a task force to develop strategies to incorporate CAM wellness and prevention activities in Federal programs such as Head Start, Meals on Wheels, The Special Supplemental Nutritional Program for Women Infants and Children, Healthy Mothers/Healthy Babies Program, and the State Children's Health Insurance Program.

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[1] - The ten leading health indicators are: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care.

85. The Commission recommends that the Secretary, DHHS, establish a task force to develop strategies to incorporate CAM wellness and prevention in health care delivery programs such as the Department of Veterans Affairs Hospitals, community and migrant health centers, maternal and child health programs, and school health programs.

86. The Commission recommends that the Secretary, DHHS, establish a task force to develop strategies to incorporate CAM wellness and prevention activities in the nation's hospitals and long term care facilities and programs serving the aging, dying, and those with chronic illness.

Coordinating and Centralizing Federal Cam Efforts

87. The Commission recommends that The President, Secretary of the Department of Health and Human Services, or Congress should create an Office at the highest possible and most appropriate level with sufficient staff and budget to perform functions that include, but are not limited to, coordination of Federal CAM activities; Federal CAM policy liaison with conventional health care and CAM professionals, organizations, institutions, and commercial ventures; planning and convening conferences, workshops, and necessary advisory groups, centralized Federal media point of contact; and facilitation of implementation of the WHCCAMP recommendations.

INSTITUTE OF MEDICINE
Board on Health Promotion and Disease Prevention

Use of Complementary and Alternative Medicine (CAM) by the American Public

With the increased use and acceptance of CAM, it is becoming increasingly important to develop a systematic and evidence-based understanding of the field and to create a framework to guide decision-making in research, regulatory policy, and in managing the interface between CAM and conventional health care. Although significant advances have been made in developing a research agenda in CAM, barriers to the successful conduct of research are numerous. The challenges in regulation, training, and practice are even more formidable.

The pressure points across the health system will shortly increase in number and intensity. The Presidential Commission on CAM appears likely to propose an ambitious agenda for the inclusion of CAM in health professions education, training, coverage under public and private health insurance, eligibility for federal training grants, and in other domains. No framework currently provides a scientifically based, transparent and publicly accountable approach to addressing the use of CAM therapies.

The results of this project could be used to facilitate and inform the decision-making of scientific and policy-making organizations, educators and practitioners. The results could also provide a logical, evidence-based framework for addressing emerging issues related to use of CAM therapies, including issues related to scientific research, oversight and regulation, reimbursement, medical education, and relationships among the allied health professions.

The IOM proposes to convene a study committee to explore the scientific and policy implications of the use of Complementary and Alternative Medicine (CAM) therapies by the American public. Specifically, the study will:

(1) describe the use of CAM therapies by the American public—providing a comprehensive overview, to the extent data are available, of the therapies in wide-spread use, the populations that use them, and what is known about how they are provided;
(2) identify major scientific and policy issues related to CAM research, regulation, interface/integration with conventional medicine, and training and certification; and
(3) develop a conceptual framework(s) to guide decision-making on these important issues and questions.

The types of questions that might be considered by the committee include:

- **Research:** What are major methodological difficulties in evaluating some CAM therapies and how do these relate to issues in regulation and practice?
- **Regulation:** What is the status of CAM regulation in the U.S. and the major areas of vulnerability that result from current policy? What regulatory approaches are used in other countries?
- **Interface/integration:** What is the current status of third party coverage for CAM, or provision of CAM in public programs? What types of evidence threshold should be established for incorporation of CAM into insurance plans and care programs?
- **Training and certification:** How should health professions' education and training programs incorporate knowledge about CAM into their curricula? How should states approach licensure and certification issues?

American Journal of Public Health Special Issue on
Complementary and Alternative Medicine: Call for Papers
Deadline for Submissions: February 1, 2000
Special Issue Publication Date: October 2002

Dear Colleague:
The **American Journal of Public Health (AJPH),** the official journal of the **American Public Health Association (APHA),** is issuing a formal call for research papers on Complementary and Alternative Medicine (CAM) for a special issue to be published in October 2002. The Journal recognizes that public health research on CAM has, in the past, faced significant challenges in terms of funding and outlets for publication. Other significant changes in research approaches and analysis have occurred, such as in research addressing indigenous health systems (traditional medicine). Recognizing the broad implications for public health theory and practice of these advances, and the challenges to the wide dissemination of these findings in the past, the Journal **will publish a special issue devoted to CAM research in October 2002.**

Original unpublished research is urgently needed to advance understanding of CAM and its potential to further public health. Research addressing indigenous health systems, special populations, or under-represented groups is especially encouraged. **The deadline for all research submissions for the CAM special issue is February 1, 2002.**

Papers that report the results of original quantitative or qualitative public health research are published as Articles (up to 3500 words, 4 tables/figures, and a structured abstract of 120 words). Preliminary or novel findings may be reported as Briefs (up to 800 words, 2 tables/figures, no abstract). **Further information** on the publication requirements for AJPH may be found online at **http://www.ajph.org/misc/ifora.shtml.**

Informal inquiries: The editors cannot respond to individual queries regarding the appropriateness of planned contributions. Formal submissions gain our full attention. Please note that we are not requesting editorials or commentaries. Unsolicited submissions on CAM other than Articles or Briefs will not be peer reviewed.

Special Instructions: Please submit all papers, along with a list of six suitable and willing peer reviewers, directly to AJPH Submissions, 800 I St., NW, Washington, DC 20001-3710. Please be sure to include in your cover letter that your research paper is intended for the CAM special issue, in order to assure timely routing for review.

Sincerely,

Duchy Trachtenberg, MSW, LCSW-C, APHA Governing Councilor &
Chair, Alternative & Complementary Health Practices -
Special Primary Interest Group (ACHP-SPIG)
Duchy@erols.com **301-984-5831 (office); 301-437-8631 (cell)**

Vincent M. B. Silenzio, MD, MPH
Guest Editor, AJPH
Working In close collaboration with the Editorial staff of AJPH, the Harlem Health Promotion Center of Columbia University, and the Centers for Disease Control and Prevention (CDC).

The mission of the American Journal of Public Health is to promote public health research, policy, practice, and education. The journal aims to embrace all of public health, from global policies to the local needs of public health practitioners.

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Overview Principles

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SG
O-M
FSMH

Paul Good

Bob Temple

March 29

6 Nov 01

I've marked 3 articles about a return to fee-for-service and one on CAM coding.

Fyi

Joe

CAM Coding

CAM Coding

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6 Nov 01
I've marked 3 articles about a return to fee-for-service and one on CPT coding.
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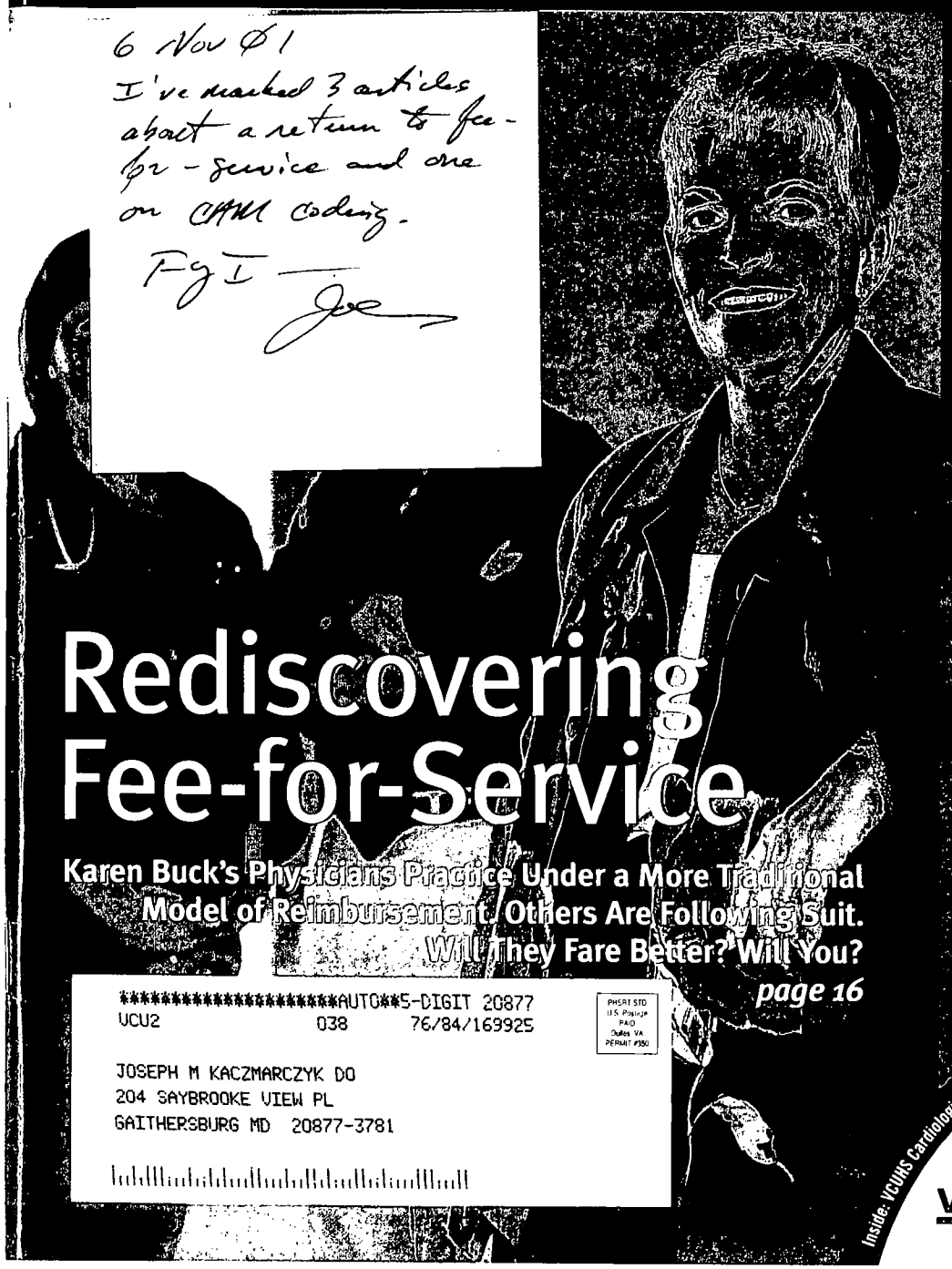
CPT coding



Rediscovering Fee-for-Service

Karen Buck's Physicians Practice Under a More Traditional Model of Reimbursement. Others Are Following Suit. Will They Fare Better? Will You?

page 16

Inside: VCUHS Cardiologists Use Technology to Treat Restenosis

Rediscovering FEE-FOR-SERVICE

Physicians Are Returning to a Traditional Method of Reimbursement — *But Are They Better Off?*

BY Bonnie Darves

AH, THE GOOD OLD DAYS. There once was a time when physicians didn't have to worry too much about getting paid for the care they provided their patients. They certainly weren't concerned with such managed-care mumbo jumbo as "prospective risk adjusters" and "carve-outs," either. They simply equated quality care with giving medically necessary treatment and counted on being paid a fair fee — both situations under their control.

So it's no surprise that many disillusioned doctors these days, working harder and earning less than ever before under managed care, long for a return to those halcyon days of yore when they were simply paid a fee for every service rendered.

But they should be careful what they wish for. "Fee-for-service," as the old reimbursement method is known, isn't likely to deal a final blow to managed-care-inspired capitation, industry watchers say. And they warn that future contracts between doctors and payers certainly won't look like those from "the good old days" of the late '80s and early '90s. Instead, they say, expect to see some serious strings attached — in the form of heavy fee discounting, cost and quality profiling of individual physicians, and less influence in negotiating both rates and contract terms — raising the question whether a return to fee-for-service will put physicians in better financial stead than they are under capitation. In fact, there may be a hefty price tag for freedom as physicians strike their own deals and lose collective clout at the bargaining table. Planning and preparation for a conversion to fee-for-service is essential and possible, however — forewarned is forearmed.

>> *continued on page 18*

Rediscovering Fee-for-Service

inter:view

Barry Slaver

Leland R. Kaiser, PhD

NAME
Leland R. Kaiser, PhD

EDUCATION
BA, psychology, MA, clinical psychology, University of Colorado; MPH, medical care administration, University of Pittsburgh; PhD, higher education, University of Denver.

CAREER HIGHLIGHTS
Author of multiple papers and publications, contributor to periodicals, and frequent lecturer; 2000 recipient of Outstanding Achievement Award for Education from the Philanthropic Service for Institutions; 2000 Changemaker Award from the Center for Health Design.

You'd Better Shop Around

Pick the Right Codes for Nontraditional Patient Encounters

by Cheryl L. Toth

Debbie Hanley

Healthcare-savvy consumers continue to demand more varied services from their physicians; physicians, in turn, are looking to expand their patient care offerings as a way to meet demand — and to increase their incomes.

If you've thought about conducting group visits, offering alternative treatments, or communicating with patients online, you might be surprised to learn that each of these non-traditional visits is a billable event. But beware: Although they may be *billable*, the encounters may or may not be *reimbursable* by insurers. Before you decide to initiate such services, make sure you have your reimbursement facts straight.

Many practices are finding that group visits offer a cost-effective alternative to the traditional one-on-one, 15-minute visit. Documented benefits include improved patient satisfaction, better compliance, lower expenses, and fewer repeat and ER admissions. Drop-in medical group appointments, or DIGMAs, are a popular type of group visit, developed by Edward B. Noffsinger, PhD, of the Palo Alto Medical Foundation in California. According to Noffsinger, "DIGMAs are not support groups and not classes. They are like a series of individual office visits with the added benefit of having both a physician and a behavioral health professional run the group."

DIGMAs generally meet during a regularly scheduled period of time and there are no criteria, such as a specific medical condition, for participation. Patients are simply asked to register in advance so their charts can be pulled. Patients like this open access to their physician, and they benefit from other patients' experiences, too.

Do group visits pay?

Is a DIGMA billable, you wonder? If you can meet the criteria of an E&M (evaluation and management) visit, yes. That means physicians must review patient charts prior to the visit and schedule an examination with each patient in the group either before or after the DIGMA. After documenting the exam and the patient's interaction, select the appropriate level of established visit code (99211-99215).

>> *continued on next page*

Read More About It

Visit our Web site, www.physicianspractice.com, to read more about offering alternative care to your patients. By typing "alternative" into the search engine on the home page, you will find a number of related resources, including Q&As, feature-length articles, and tools. Following are some highlights:

- *"Alternative Trends."* Read this article to find out how some physicians are adding alternative care services (also known as complementary or integrative services) to their practices and succeeding with patients and with their payers.
- *"Docs Dig the DIGMA."* This article goes into more detail on how drop-in group medical appointments work and includes different models physicians are using.
- *PPD Interview with Andrew Weil, MD.* Read about how Dr. Weil started an alternative health program at the University of Arizona Health Sciences Center.
- *Compliance plan basics.* If you're having coding problems with DIGMAs and other forms of alternative medicine, read our Q&A about the fundamental elements you need in a compliance plan, complete with a link to the model plan drafted by the Office of the Inspector General.

>> continued from previous page

Educational and other group visits are frequently offered to patients with the same condition. OB/GYNs, for example, may hold childbirth classes. While these classes are typically not reimbursable, many practices do charge patients for the classes and collect the fee in full. One orthopedist in Texas uses educational group visits to inform total knee replacement patients about their recovery. He considers this part of the education process included in the global fee, and does not bill the session separately.

According to internist and geriatrician John Scott, of the Co-Op Health Care Clinic at Kaiser Permanente in Colorado, visits for patients with a shared condition "are typically held monthly, last about four hours, and include a review of patient charts, examinations, and a review of treatment plans. They can be especially effective for a geriatric patient base."

In most cases these visits are billable if you can clearly document that you performed a history and examination, reviewed a plan of treatment, or conducted medical decision making in the visit. Document these activities in the patient's chart, and you may bill an established outpatient visit code.

Consider the alternative

It's no secret that Americans are demanding alternative treatments such as acupuncture, chiropractic, massage therapy, and herbal remedies more than ever. If you are considering introducing an integrated model to your patients by offering alternative modalities, sort through the reimbursement issues before making a final decision.

"Anyone who tries to bill for alternative care should not do so without being fully informed," according to David Edelberg, MD, medical director of WholeHealth Chicago, an integrated medical model that offers care by medical doctors as well as chiropractors, acupuncturists, and massage therapists. "Although many policies do reimburse for chiropractic care, it's the rare plan that makes it easy to get paid for other alternative medicine services. We often found ourselves writing letters of medical necessity and sending documentation for months before the plan would pay."

Mary LeGrand, coding instructor and consultant for St. Louis-based Karen Zupko & Associates Inc. agrees. "Although CPT codes exist for acupuncture, manipulation, and bodywork, that doesn't necessarily mean that they will be paid." Says LeGrand, "Each state has different requirements about alternative practitioner licensing, and who must perform alternative services in order to make them reimbursable."

LeGrand is quick to point out, however, that MDs and DOs who perform an office visit that includes a documented history, examination, and medical decision making, can bill for an E&M visit. "If a patient presents with lumbar pain, headache, or arthritis, and the physician prescribes an herb or course of acupuncture, the visit can still be billed as an E&M as long as documentation criteria are met."

Still, it's accurate to say that, while reimbursement for alternative treatments is catching on slowly, most plans still do not reimburse for alternative therapies. Several practices agree that it's best to collect your full fee for treatments by alternative practitioners up-front, and then help the patient bill his or her insurance company.

After several years of billing difficulties that resulted in a large backlog of accounts receivable, WholeHealth Chicago has gone to a patient pay system for anyone who receives alternative services. "We ask for the patient's credit card when they call for their appointment," says Edelberg.

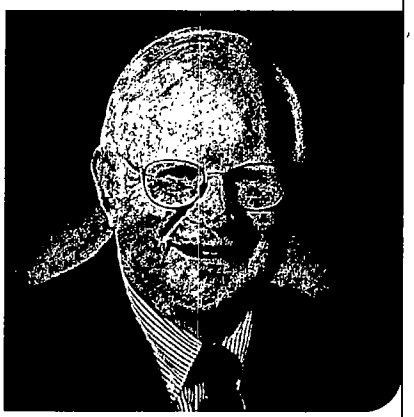
net.results

Get a Line on Coding The following Web sites provide additional information about nontraditional visits and related coding and reimbursement issues.

- Read an article about various types of group visits and their impact on patient satisfaction and quality of care.
  www.hippocrates.com/FebruaryMarch2001/02features/02feat_digma.html
- This site provides answers to a number of specific chiropractic coding and reimbursement questions, as well as information about the American Chiropractic Association's coding tools and educational programs.
  www.amerchiro.org/insurance/coding_home.html
- Review a state-by-state list of licensure requirements for acupuncturists, including where and when acupuncture falls within the scope of practice for physicians.
  www.medicalacupuncture.org/acu_info/licensure.html
- This company offers physician-patient Web service tools and provides transaction services for the virtual office visit.
  www.medfusion.net
- This physician-patient interface company offers online tools for conducting patient e-mail visits.
  www.healinx.com

2nd:opinion

Make Fee-For-Service Pay—For Everyone



by Dean C. Coddington

Over the past 15 years or so, most physician leaders, hospital executives, and those involved in strategic planning (like myself) believed that capitation was gradually replacing fee-for-service medicine. Limiting the use of medical services by shifting the financial risk from the insurers to the physicians made economic sense. However, more recently, evidence has been mounting that capitation has topped out, and in many advanced managed-care markets, it is in definite decline.

What are the implications for physicians in this reversal of the power of HMOs? Mixed, at best. A few medical groups, especially primary-care physicians in certain metropolitan markets, have learned how to limit utilization and make more money.

On the other hand, the majority of physicians dislike managed care, especially HMOs and capitated payment. They find the controls that come with capitation to be costly and onerous, and the incentives to do less for patients to be immoral. So, in many physicians' offices around the country, there is a sense of relief that the long winter of managed-care discontent may be coming to an end.

Who bears the burden?

That relief may not be shared by everyone. Despite the reality that much of fee-for-service payment is heavily discounted, the fact remains that constraints on utilization are fading away while healthcare spending is projected to increase at $100 billion a year. Moreover, most patients are beginning to experience huge annual increases in their health costs, some of which are being passed on in the form of higher deductibles and copayments, and responsibility for sharing a larger piece of the premium with employers. So, while physicians may cheer the chance for greater medical decision making and increased incomes, it is unrealistic to expect others — especially employers, employees, and government payers — to welcome, let alone pick up the tab for, the return of fee-for-service.

That's the bad news; now for the good. Physicians have the opportunity now to lead the charge to control variations in medical procedures and reduce the use of inappropriate and unnecessary care — both problems at the heart of managed care. Here are my top suggestions:

- Become a leader in the use of clinical information technology (IT), electronic medical records, and medical databases. Advances in clinical IT can reduce clinical variation and lead to lower annual cost increases.
- Get involved in developing or promoting disease management programs for patients with chronic illnesses, such as diabetes and congestive heart failure. According to statistics, 20 percent of all patients account for 80 percent or more of all healthcare costs. Therefore, physicians must find ways to control the costs of caring for the sickest patients.
- Find new approaches to assessing the cost-effectiveness of how you practice medicine. Without the limits of capitated payment, employers, government payers, and patients need assurances that what is being done to patients meets the tests of both clinical efficacy and reasonable costs.
- Develop a reputation for providing not only high-quality care, but also efficient care, by using your resources wisely (e.g., avoiding duplication of tests, retrieving medical records quickly, scheduling efficiently, etc.).

Yes, this is an exciting period for physicians who have long decried the controls of capitation. However, moving back to fee-for-service poses long-term challenges. There may be short-term financial benefits, but these won't last long without innovative approaches to assuring payers that utilization is under control. PPD

Dean Coddington is senior consultant with McManis Consulting, and author of numerous healthcare articles and books. He can be reached at dcoddington@physicianspractice.com.

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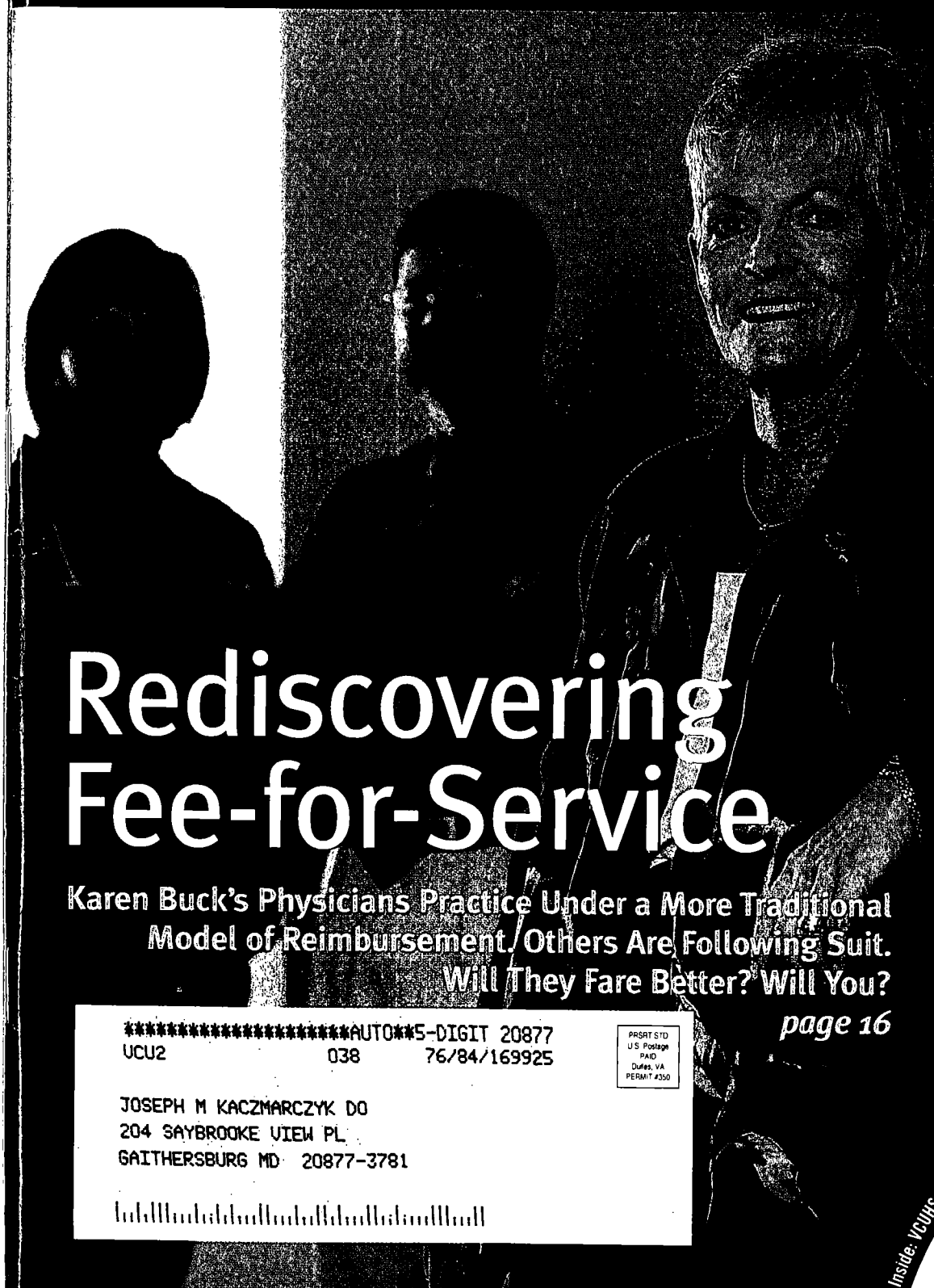

Rediscovering Fee-for-Service

Karen Buck's Physicians Practice Under a More Traditional Model of Reimbursement. Others Are Following Suit. Will They Fare Better? Will You?

page 16

Inside: VCUHS Cardiologists Use Technology to Treat Restenosis

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
BETHESDA, MARYLAND 20014

BUREAU OF HEALTH MANPOWER

JAN 30 1975

Reginald R. Gold, D.C., Ph.C.
Vice President
Sherman College of Chiropractic
P. O. Box 1452
Spartanburg, South Carolina 29301

Dear Dr. Gold:

Thank you for your letter of January 9 in which you bring to our attention problems of nomenclature as they may affect the practice of chiropractic.

You posed certain specific questions. Before answering them, I think it would help if I make the Department's position and authority clear as it affects the legal authorization for the scope of the practice of any health professional.

The responsibility for defining and limiting the scope of practice of any health profession lies with the individual States which, through practice acts and licensure, regulate what it is that independent practitioners may or may not do within that State. No Federal laws or regulations supersede these. The Department does, however, specify certain terms and conditions for Medicare and Medicaid reimbursement of health professionals under the Social Security Act. These Departmental regulations again, however, do not supersede State requirements or limitations on practice and cannot be construed as granting chiropractors (or other health professionals) permission to carry out procedures which are not authorized by the laws and regulations of the various States.

The terms "Primary Health Care" and "Primary Health Care Provider" are used by Congress and the Department to identify an area of emphasis for health care delivery. Where these terms are used in legislation to indicate types of services or occupations in which some special consideration is to be given, they require a detailed interpretation in the appropriate regulations. In applying the term "Primary Health Care Provider" to any health profession, whether it be chiropractic, medicine, dietetics or audiology, there is no intent or authorization to change or even define the authority, scope of practice, or function of the occupation concerned. Therefore, the term "Primary Health Care Provider" as it is applied to chiropractors has no effect upon statutes and regulations which define or limit the scope of chiropractic, and does not permit them to perform diagnostic examinations of the entire body.

Similarly this term does not mandate chiropractors to perform diagnostic examinations of the entire body.

Your interpretation of the term "Primary Health Care Provider" as recognizing that a profession has "first contact" with a patient (as opposed to a "Secondary Health Care Provider" to whom a patient is referred by a "Primary Health Care Provider") is reasonably accurate. I have attached the definition of Primary Health Care which this Bureau has recently developed. As you can see, many types of health professionals will have some function that falls within this definition. There is no definitive list at this time of "Primary Health Care Providers".

Legal restrictions on the use of the term "physician" are to be found in the various State statutes. The Department does not use or recognize the term "Chiropractic Physician" in any sense that would dictate the scope of chiropractic practice.

I hope this information will clarify the Department's use of terminology with respect to chiropractic. I would like to reiterate that no action by the Department can alter the statutes and regulations in force in the various States which govern the practice of chiropractic, and no action of the Department should be construed as constituting or being founded upon a legally valid interpretation of these statutes and regulations.

Sincerely yours,

David A. Kindig, M.D.

David A. Kindig, M.D.
Deputy Director

Enclosure

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001. fax	cover, Veronica Gutierrez to Steve Groft (1 page)	11/12/2001	b(6)

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[001]

FAX

To: Steve Goff

From: Veronica Gutierrez, D.C.

cc:

Date: 11-12-01

Number of Pages, including cover sheet:

Phone (b)(6) O:360-658-3618
Fax: H 360-851-2344
e-mail: Veronicapgdc@AOL.com

Remarks:

I think this letter is helpful in the discussion of defining a Primary Care Provider

For the commission file!

Thank you — Again!

Veronica

Two Recommendations Regarding Homeland Security and the Sequelae of the September 11th attacks

1) The Commission recommends that the utility of CAM approaches (massage, musculoskeletal manipulation and mind-body therapies in particular) in dealing with those affected by the events of September 11th be documented and that information about this work be made available to caregivers and to the public.

2) The Commission recommends that emergency medical service personnel, other "first responders", and those who work on an ongoing basis with those traumatized by terrorism or its threat be trained in the use of mind-body approaches to deal with their own stress and trauma and that of those they serve. The Commission also recommends that these personnel also be informed of the possible utility of other CAM approaches for people who have been traumatized.

From
American Journal of Health-System Pharmacy

Retrospective Analysis of Mortalities Associated with Medication Errors

Jerry Phillips, Sammie Beam, Allen Brinker, Carol Holquist, Peter Honig, Laureen Y. Lee, and **Carol Pamer**

Abstract

The types, causes, contributing factors, and patient demographics of fatal medication errors were reviewed.

Case reports of medication errors from hospitals, ambulatory care settings, and patients' homes that were entered in FDA's Adverse Event Reporting System during 1993- 98 were the source of information on fatal medication errors. Each report was classified using predefined criteria and a taxonomy developed by the National Coordinating Council for Medication Error Reporting and Prevention. The types, causes, contributing factors, and patient demographics were identified, and the causality of each case was assessed to prevent future fatalities.

The data indicated 5366 medication error reports. Fifty-nine reports were excluded and classified as duplicate reports or intentional overdoses. Of the remaining medication error reports, 68.2% resulted in serious patient outcomes and 9.8% were fatal. Of the 469 fatal medication error reports, 48.6% occurred in patients over 60 years. The most common types of errors resulting in patient death involved administering an improper dose (40.9%), administering the wrong drug (16%), and using the wrong route of administration (9.5%). The most common causes of errors were performance and knowledge deficits (44%) and communication errors (15.8%). Fatal medication errors accounted for approximately 10% of medication errors reported to FDA and were most frequently the result of improper dosing of the intended drug and administration of an incorrect drug.

A review of case reports of medication errors from 1993 to 1998 yielded information on the most frequent causes of and contributing

NEXT SECTION

Section 1 of 5

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Abstract and Introduction
Methods
Results
Discussion
Conclusion
References

INTERACT

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RECOMMENDED LINKS

MEDSCAPE NETWORK
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RELATED SPECIALTIES
Cardiology
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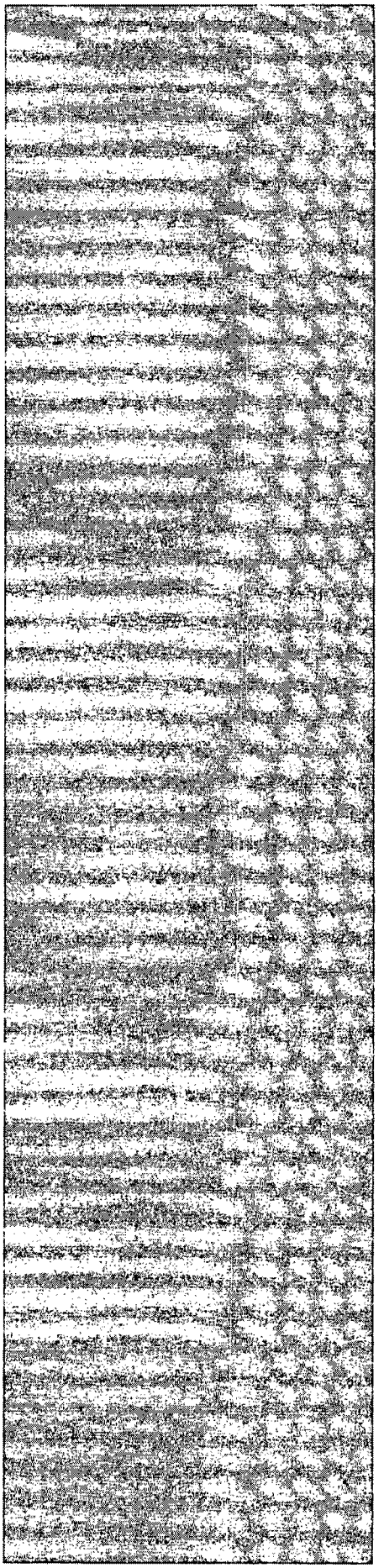
Family Medicine
Infectious Diseases
Internal Medicine
Managed Care
Neurology
Pharmacotherapy
Primary Care
Pulmonary Medicine

yielded information on the most frequent causes of and contributing factors involved in fatal medication errors. [Am J Health-Syst Pharm 58(19):1824-1829, 2001. © 2001 ASHP, Inc.]



Introduction

A medication error, as defined by the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP), is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. Medication misadventures, a broad categorical group, include adverse drug events (ADEs), adverse drug reactions (ADRs), and medication errors.[1]

ADRs result in injuries that are-unavoidable and may be classified as type A or type B.[2] Type A ADRs are known and need to be better quantified. They are usually predictable and dose dependent (e.g., respiratory depression with opiates). Type B ADRs are unknown and need to be quickly identified, quantified, and communicated. They are usually idiosyncratic (e.g., liver toxicity associated with troglitazone).

ADEs cause injuries that are known and expected (e.g., drowsiness from diphenhydramine).[3] They may be classified as preventable or unavoidable.

Medication errors are preventable events that may cause or lead to inappropriate medication use or patient harm and may be classified as potential or actual. Potential errors are defined as reports of confusion or an intuition that an error will occur in the future. They are not considered ADRs or ADEs. Actual errors may or may not reach the patient. For example, when the wrong drug is prepared but system checks prevent the drug from being administered to the patient, an actual error that did not reach the patient occurred. Again, this type of error is neither an ADR nor an ADE. Medication errors that reach the patient either cause harm or no harm. For example, when an extra dose is administered with no adverse outcome, no harm is done to the patient. This is neither an ADE nor ADR. However, if a patient's death was caused by an unintentional overdose of warfarin, this would be classified as a preventable ADE.

The November 1999 Institute of Medicine report To Err Is Human estimates that medication errors account for 7000 deaths per year. ADRs may be responsible for more than 100,000 deaths nationwide

each year and may be between the fourth and sixth leading causes of death in the United States.[4] It has been estimated that more than 50% of 1.8 billion prescriptions are used incorrectly and that drug-related problems, including ADRs, account for nearly 10% of all hospital admissions and up to 140,000 deaths annually in the United States.[5] Drug-related morbidity and mortality in the United States have been estimated to cost the American health care system $76.6- $136 billion annually.[6]

In a case-control study covering a four-year period at a single hospital, there was an almost twofold increase in the risk of death associated with ADEs, of which 1% was attributable to medication errors.[7] In the Harvard Medical Practice Study, ADEs accounted for 19.4% of all disabling adverse events, of which 45% were caused by medication errors, and 30% of patients with drug-related injuries died.[8] In a prospective cohort study, 247 ADEs were evaluated, of which 28% were judged preventable, 1% were fatal (not preventable), 12% were life-threatening, 30% were serious, and 57% were significant.

Medication errors may result from single or multiple breakdowns in a system's continuum of diagnosing an ailment, planning a therapeutic regimen, prescribing and dispensing drugs, and administering the drug. In a systems analysis of a prospective cohort study evaluating 264 preventable ADEs, 78% of the errors were caused by seven system failures, and the leading problem (29%) was attributed to the failure to disseminate drug knowledge.[8] In another study that evaluated 696 errors, the most common causes were related to drug knowledge (30%), knowledge about the patients (29.2%), the use of calculations and decimal points (17.5%), and nomenclature issues (incorrect drug name, dosage form, or abbreviation) (13.4%).[9]

We reviewed all reports of death associated with medication errors received by FDA that were entered into the Adverse Event Reporting System (AERS) database over a six-year period to better understand the drug products involved and the various risk factors and root causes associated with these preventable adverse events.

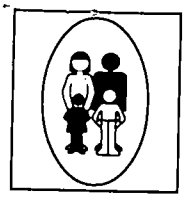
continued...

Capt Jerry Phillips is Associate Director, Office of Post-Marketing Drug Risk Assessment, Center for Drug Evaluation and Research (CDER), Food and Drug Administration (FDA), Rockville, MD, and Chair, National Coordinating Council for Safe Medication Practices, Rockville, MD. **Sammie Beam** is Safety Evaluator; **Allen Brinker, M.D.**, is Epidemiologist; **Carol Holquist** is Safety Evaluator; **Peter Honig, M.D.**, is Director; **Laureen Y. Lee, PHARM.D.**, is Safety Evaluator; and **Carol Pamer, Pharm.D.**, is Safety Evaluator, Office

of Post-Marketing Drug Risk Assessment, CDER, FDA.

Address correspondence to: CAPT Phillips at the Office of Post-Marketing Drug Risk Assessment, HFD-400 Room 15B03, U.S. Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857 (phillipsj@cder.fda.gov).

NEXT SECTION



GUTIERREZ FAMILY CHIROPRACTIC

Dear Steve,

Nice mail from me!

Here's an example of a model law that I've been suggesting each profession have on file with the new "Collaborative & Integrative Health Care" Office.

States would not have to adopt, but could reference for their own information.

Hope this note finds everyone there feeling safe and healthy.

-Verena
10-24-01

3704 - 172ND ST. NE, SUITE N • P.O. BOX 3069 • ARLINGTON, WA 98223
(360) 658-3818 • Fax (360) 651-2344

Model Statute - Draft #1 - Presented for consideration by the Council on International
Chiropractic Law of the World Chiropractic Alliance, Washington, D.C., 3 March 2000

Section 1. Title. This act shall be known as, and may be cited as, the "Chiropractic Title and Practice Act."

Section 2. Definitions. The following words and phrases when used in this act shall have, unless the context clearly indicates otherwise, the meanings given to them in this section.

"Accredited" means that the institution, if located in Canada or in the United States of America, held at some time during the person's period of matriculation or subsequent thereto, the status of "accredited," "candidate for accreditation," or "recognized candidate for accreditation" with an accrediting agency that, at that same time that such status was in effect, met at least one of the following standards: a member of the Association of Specialized and Professional Accreditors, a participating organization in the Council for Higher Education Accreditation, or an accrediting agency recognized by the United States Department of Education. If the institution is located outside of Canada and the United States of America, it means that the institution had, at the time of the chiropractor's graduation therefrom, an affirmative grant of degree-granting power from the appropriate government agency of the nation or political subdivision in which it was located.

"Chiropractic" shall mean the philosophy, art and science of preserving, restoring and maintaining health by locating, analysing, and correcting vertebral subluxations.

"First professional degree in chiropractic" shall mean, if awarded in Canada or in the United States of America, the degree Doctor of Chiropractic (D.C.) If awarded in another country, it shall mean the degree ordinarily awarded by chiropractic postsecondary institutions in that country upon the successful completion of a program of study of not less than four years in preparation for the practice of Chiropractic.

Section 3. Qualifications. The qualifications of a Chiropractor are that the person shall hold a first professional degree in Chiropractic from an accredited institution, or shall hold a current license to practice Chiropractic from another nation or political subdivision thereof, or both. If a person meets these qualifications but subsequently commits a crime, a court of competent jurisdiction may, as part of the sentence for committing the crime, enter an order that the person be disqualified for such period of time, or until some contingent event occurs, as it may direct.

Section 4. Titles. No person shall hold himself out to the public as a Chiropractor, as a Doctor of Chiropractic, or as a Chiropractic Physician, nor advertise or describe his occupation or profession as Chiropractic or Chiropraxis, unless he meets the qualifications established in Section 3 and is not disqualified thereunder. This section shall not prohibit the use of the title Chiropractic Assistant by an employee of a Chiropractor. Violation of this section shall constitute a criminal offence and shall be punishable by a fine not exceeding $10,000, or imprisonment not exceeding one year, or both.

Section 5. Practice. A person who meets the qualifications established in Section 3, and who is not disqualified thereunder, may practice Chiropractic, may utilize any of the titles enumerated in Section 4, and may charge and receive payment for providing Chiropractic services.

Section 6. Supersession. This act shall supersede and take precedence over any other law to the contrary, except as expressly provided herein.

Section 7. Effective date. This act shall take effect immediately.

Too long should be content, esp. Hx

PART TWO

OVERVIEW OF CAM IN THE UNITED STATES:

DEFINITION AND DESCRIPTION, HISTORY, AND CURRENT STATUS

Defining and Describing CAM

Definition

Complementary and alternative medicine is a heterogeneous group of medical, health care, and healing systems, with their accompanying worldviews, theories modalities, products, and practices other than those intrinsic to mainstream healthcare in the United States. CAM includes all such systems, practices, and products that have to do with preventing and treating illness and promoting health and well-being. Although heterogeneous, the major CAM systems have many common characteristics, including a major focus on individualizing treatments, treating whole people and systems, promoting self-care and self-healing, and supporting vitalism and spirituality. Many CAM systems have characteristics also commonly found in some branches of mainstream healthcare, such a focus on good nutrition and preventive medicine. Thus, boundaries between CAM and mainstream medicine as well as between CAM systems are often blurred and constantly shifting and evolving.

Description

Some of the health care systems, practices, and products that are typically classified as CAM in the United States are listed in Table 1, below.

Table 1: Common CAM Therapies and Systems of Medicine Offered in the U.S.

*Acupuncture	Chiropractic	Naturopathic Medicine
*Acupressure	(Sacral) Cranial Osteopathy	Nutritional Therapy
Alexander Technique	Environmental Medicine	*Qigong
Applied Kinesiology	*Herbal Medicine	Reflexology
Anthroposophic Medicine	Homeopathy	Relaxation and Visualization
Aromatherapy	Hypnosis	Reiki
Autogentic Training	Imagery	Shiatsu
Ayurvedic Medicine	Massage and Bodywork	Spiritual Healing
Bioelectromagnetics	*Meditation	Therapeutic Touch
Energy Medicine	Mexican-American Medicine	Traditional Chinese Medicine
Feldenkrais	Native American Medicine	*Yoga

*Many CAM therapies and practices are derived from complex systems of healthcare and healing and are typically delivered within the context of the overall care rather than as a stand-alone therapy, although they may be delivered as stand-alone treatments by those who are not trained in the particular system of medicine.

Adapted from Zollman C, Vickers A. What is complementary medicine? BMJ 1999;319:693-696

Common Characteristics of CAM Systems

Despite their diversity, there are a number of similarities among the major CAM systems listed in Table 1. These similarities include a focus on:

a) Whole systems - CAM systems tend to emphasize a complete or combination systems approach that includes multiple simultaneous interventions with individualization, or variation, of those interventions during the course of treatment. They often assume that the entire system is required as a package independent of the isolated effects of its individual components (e.g., the use of whole plant extracts rather than isolated active ingredients). For example, a chiropractor, in addition to providing a spinal adjustment, may also offer advice on diet and exercise, provide guidance on breathing and relaxation, and prescribe nutritional supplements.

b) Stimulating Self-Healing Processes - CAM systems tend to emphasize the stimulation or support of natural healing processes, referred to as *vis*

medicatrix naturae (the healing power of nature) and seek to enhance those processes in order to accelerate the natural course of recovery, rather than mask or suppress the symptoms of the disease. (e.g. nutritional & diet therapy for rheumatic diseases rather than immuno-suppressants.). Even CAM modalities that are not directly evolved from traditional systems of medicine, have adopted the philosophy that the body's self-healing mechanism can be speeded up, sometimes to an astonishing degree, by the proper stimuli. Thus, many CAM practitioners employ therapies designed to stimulate the patient's constitution to fight on its own behalf, on the assumption that this emphasis on enhancing the natural healing process is the most appropriate foundation of any medical therapy (House of Lords, 2000).

c) Promoting Self Care - CAM systems tend to emphasize a practitioner-patient partnership in looking at options. There is also an emphasis on promoting self responsibility and promoting interventions that incorporate quality of life, patient preferences, and patient satisfaction into the therapeutic and diagnostic decision-making processes.

d) Energy - Many CAM systems emphasize the need to achieve balance of energy in order to promote a higher, or optimal, level of functioning above the mere absence of illness. Restoring harmony and promoting optimal functioning is a major focus of many CAM systems, including Ayurvedic Medicine, Native American Medicine, Homeopathic Medicine, Traditional Chinese Medicine, Naturopathic Medicine, and Chiropractic.

e) Spirituality - There is a significant spiritual component to many of the systems of medicine that are typically classified as CAM. Most of these traditional systems of medicine--such as Ayurvedic Medicine, Traditional Chinese and Oriental Medicine, and Native American Medicine--place a great deal of importance on the role of spirituality in maintaining health and treating disease. For example, the fundamental concepts of Traditional Chinese and

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

Many of the CAM health care systems and practices have evolved out of clinical experience, ranging from small groups who use a single intervention (e.g. neural therapy, polarity) to widely used, elaborately detailed systems such as Traditional Chinese Medicine. These health care systems and practices have become associated with CAM because they have been marginalized or underutilized by conventional, or mainstream, health care as critical ingredients to the delivery of high-quality health care. The marginalization has occurred for a variety of reasons, including:

a) Alack of an understanding or acceptance of the explanatory model or models underlying the system (e.g., homeopathy, chiropractic) by mainstream health care professionals. While mainstream clinicians tend to formulate theories and then deduce therapies from them; CAM healers tend to reverse this process, that is, develop explanatory theories based on clinical observations of responses to treatment. The dedication of some CAM systems of health care to simplistic, all-inclusive theories gives them the appearance of sectarian fanaticism in mainstream medicine's eyes (Whorton, 1999).

b) The origin of the system from cultures outside of the U.S. or from indigenous cultures (e.g., Ayurvedic Medicine, Traditional Chinese Medicine, Native American Medicine). Because these systems often rely on low technology (e.g., herbs) or self-help approaches, they are often seen as primitive and unscientific.

c) the lack of sufficient data on safety, efficacy, or potential mechanism of action to support its use for treating specific illnesses (e.g., vitamin therapy).

d) the inability to easily integrate the system into the mainstream healthcare model (see discussion below).

e) the widespread belief that the healthcare or healing system is not practical or feasible for most people, even though there is scientific consensus that it is therapeutic (e.g. environmental medicine, therapeutic diets).

f) The system or practice is not yet regulated or licensed in most states (e.g. naturopathy).

g) The amount of research funding, infrastructure, and capacity for investigating the practice is low. (e.g. herbs, nutriceuticals).

It should be emphasized that because CAM is so diverse any attempt to define or describe it is likely to be deficient or flawed from one or more perspectives. Health care systems, practices, or products that are not widely available and/or are difficult to access in one part of the United States may be readily available and quite easy to access in another. To truly understand the complexities of this definition and description of CAM, it is, thus, necessary to understand it origins, its evolution, and its current status in this country.

History: The Fall and Rise of CAM in the United States.

Before the early 19th Century, medicine in the United States was an eclectic mix of co-existing systems of medicine. In colonial and post-colonial America, there were literally dozens of competing medical philosophies, including those derived from European, Asian, African, and Native American cultures.

During this time, there were only a few hundred graduates of American and European medical schools (i.e., M.D.s) practicing in the United States and only the upper classes were able to afford their services. The vast majority of primary medical care in this country, therefore, was provided by botanical healers and midwives, supplemented by barber-surgeons, apothecaries, and a host of other lay healers offering a variety herbs and nostrums for a range of illnesses (Starr, 1982).

This landscape began to change, however, in the early 1800's. As the number of elite medical-school-trained physicians began to increase—from only a few hundred in 1800 to nearly 7,000 in 1830—they began organizing into professional societies. Many of these societies were established not only to extend the benefits of science to the masses but also to extend the base of potential revenues for their members (Kaptchuk & Eisenberg, 2001). One of their first major activities of many of these societies was to begin discredit what they deemed as "irregular" medicine.

[put a paragraph here on tactics that were used] No !!

This movement to drive irregulars out of the market place quickly backfired, as an organized wave of populist resistance emerged from a number of these medical traditions, including Thomsonians (botanical healing), Grahamites (health food), heomeopaths (microdiluted medicines), hydropaths (water therapy), and mesmerists (energy medicine). The irregulars and their followers saw these elite-trained medical professions as the bulwark of the privileged class and were able to successfully label their efforts as "anti-democratic" snobbery. (Kaptchuk & Eisenberg, 2001). These kinds of charges were particularly successful in the period of Jacksonian democracy from 1820 to 1850. During this time in America, it was commonly believed that the "common man" could do anything and be anything. This meant that laws that gave one man, one group, or one section of society an unfair advantage over another came in for a great deal of condemnation (Kaufman, 1971).

The battle lines had clearly been drawn, however. Over the next several decades, regular (M.D.) and irregular (non-M.D.) systems of health care engaged in fierce public quarrels. For example, the founder of homeopathy, Samual Hahnemann (1755-1842), lambasted regular medicine for shortening "the lives of ten times as many human beings as the most destructive wars and render[ing] many millions of patients more diseased and wretched than they were originally" (Hahnemann, 1852, p. 738). Hahnemann charges were not without merits, as regular physicians' commonly used "heroic" methods, such as blood letting, blistering, cupping, and purging, that did more harm than good (Kaufman, 1971). One commonly used treatment that came under particularly sharp attack from irregulars was of these was *calomel*, a purgative composed primarily of mercurous cholide. It was used to treat a variety of ailments and produced severe side effects--including ulceration of the mouth; a profuse, thick salivation; tooth loss; and necrosis of the jawbone--which were often significantly worse than the original ailment. (Whorton, 1999).

Regular medicine, which was championed by Oliver Wendell Holmes, the physician, Harvard Medical School professor of medicine, and poet, countered Hahnemann's criticisms by charging that homeopathy was "a mingled mass of perverse ingenuity, of tinsel erudition, of imbecile credulity, and of artful misrepresentation" (Holmes, 1842, p. ??) and "a confused mass of rubbish" (Hooker, 1949, p. 136). Other systems of irregular medicine were afforded the same level of disrespect (Whorton, 1999). It was common for orthodox health care professionals to refer to all irregulars as "quacks," "charlatans," or "snake-oil salesmen." (ref?)

A Century of Decline

From the mid-1800s to the mid-1900s, irregular health systems saw themselves being systematically forced out of the mainstream. In 1847, one year after the establishment of the American Homeopathic Society, the American Medical Association (AMA) was founded to erect a formal barrier between regular medicine and all other systems of health care. The AMA quickly established a "consultation clause," which

made it unethical for AMA members to consult with irregular healers. For the rest of the nineteenth century, this consultation clause was used to oppose the admission of irregular practitioners to local and state medical societies, the staffs of public hospitals and the military medical corps, and the faculties of publicly funded medical schools (Whorton, 1999). The AMA's Committee on Quackery internally policed its members for any signs of collaboration with irregular health care practitioners (Faner et al, 1992)

It was also during this time that AMA began sponsoring and lobbying for state licensing laws, which had been passed in many states in the early part of the 19th century but had been repealed after strong protests from advocates of irregular medicine. By the late 1800s, however, the AMA succeeded in getting most states to begin re-implementing licensing laws, but only for regular medicine. This movement was helped dramatically by the validation of the germ theory (i.e., germs are responsible for many contagious diseases) coupled with significant advances in anesthesia, surgery, hygiene, and the development of vaccines, which dramatically improved the public's health and renewed public respect for the power of regular medicine.

In response to the increasing political might of regular, or orthodox, medicine, as it was now called, many "unorthodox" health care systems began aligning themselves with social and religious activists, whom they saw as kindred victims of systematic political oppression (Kaptchuk & Eisenberg, 2001). For example, when the American Vegetarian Society met in 1855, they invited as speakers Susan B. Anthony, a leading advocate for women's rights, Horace Greeley, a leading antislavery and spiritualist proponent, and an assortment of advocates for sexual emancipation and working class rights (Nissenbaum, 1980).

Some unorthodox health care system reluctantly decided to emulate the AMA and campaign for their own separate licensing laws. Although several of these health care systems eventually succeeded, their progress was painstakingly slow in comparison to orthodox health care (Shyrock, 1967). Osteopaths, for example, were licensed in 15 states by 1901. However, it took another 71 years--until 1972--for osteopaths to be fully

licensed in every state. Chiropractic did not win its first licensing battle until 1913. Although another 21 states passed chiropractic licensing laws in the following decade, it took another 50 years—until 1973--for chiropractors to be licensed in all states. Naturopathic medicine doctors have had an even greater struggle, with only 12 states presently issuing naturopathic doctor (N.D.) licenses **(ref?)**

While they campaigned for licensing laws, the leaders of some unorthodox health care systems faced criminal prosecution for practicing medicine without a license. For example, Benedict Lust, the founder of Naturopathy, was jailed in 1899 and Daniel David Palmer, the discoverer of chiropractic adjustment, was jailed seven years later, in 1906 (Kirchfeld & Boyle, 1994; Gielow, 1981). Sometimes the prosecution was instigated from other unorthodox systems of health care rather than from orthodox medicine. For example, in 19??? osteopaths succeeded in getting chiropractors prosecuted for practicing osteopathy without a license (Gevitz, 1982)

The first half of the 20th century marked the low point for unorthodox systems of health care in this country. The Pure Food and Drug Act of 1906, which established the U.S. Food and Drug Administration, set the stage of the first successful prosecution of a purvey of unorthodox remedies just two years later, in 1908 (McGinnis, 1991). Another major setback for unorthodox healthcare came a few years later, when the Carnegie Foundation funded Abraham Flexnor, an educator and founder of the Institute for Advanced Study in Princeton, N.J., to survey the state of medical education in the United States and Canada. This survey, which uncovered deplorable education standards at nearly all American medical schools, was an acute embarrassment to the orthodox medical profession when it was released. It gave none of them a clean bill of health and served to crystallize an educational reform movement in this country that was already under way. After its release in 1910, many substandard medical institutions, orthodox and unorthodox, were driven out of business or forced to implement significantly more rigorous training programs (Whorton, 1999)

Like orthodox medical schools, Flexnor found unorthodox medical schools to be "hopelessly meager," "utterly wretched," "intolerably foul," and "absurdly" inadequate (Flexnor, 1910, pp. 197, 214, 253). Schools for many unorthodox healing systems either ceased to exist or barely hung on to their existence (Starr, 1982) Homeopathic colleges, for example, dropped from 22 schools in 1900 to only 2 by 1923 (Kaufman, 1969). The only exceptions were osteopathy, which lost only one school in the 20 years following the Flexnor report, and chiropractic schools, which actually gained schools following Flexnor's report.

The tide of public sentiment against unorthodox, or unconventional, health care, as it was now called, increased further when sulfa drugs and then antibiotics were introduced in the 1930s and 1940s. These developments suggested to the public that orthodox, or mainstream, medicine was truly the medicine of the future and that unconventional health care systems and their therapies were relics of the past (Whorton, 1999). This negative sentiment persisted and was even institutionalized for the next quarter of a century. Indeed, until 1961, the AMA continued to label osteopathy and chiropractic as "unscientific cults" and deemed it "unethical" for physicians to associate professionally with osteopathic doctors or chiropractors (Judicial Council of the AMA, 1961, p. 177, 776).

The Road Back to Respectability: From Quackery to CAM

For a variety of reasons, the second half of the 20th century witnessed a steady rebound for many unconventional systems of healthcare. There were several developments, in particular that dramatically reversed the downward fortunes of many unconventional healthcare practitioners. One of the most dramatic reversals came from an unsuspected source: the AMA itself.

Indeed, in the mid-1960s, the AMA suddenly stopped opposing the admission of osteopaths into orthodox residency programs, and even began allowing them to become AMA members. Around the same time, osteopathic physicians were included in the

Medicare reimbursement system when that act was passed. In a matter of just a few years, they had gone from being a labeled "quacks" or "cults" to being accepted into the mainstream health care.

In the early 1970s, the tide began to turn for chiropractic as well. Chiropractors, initially denied the ability to participate in Medicare because it was deemed that their "theory and practice are not based upon the basic knowledge related to health, disease, and health care which has been widely accepted by the scientific community" (Cohen, 1969, pp. 142), succeeded in winning the inclusion of their services under the Medicare system in 1974 (Moore, 1993). Just two years later, in 1976, chiropractors filed an anti-trust suite against the AMA, the American Hospital Association, and several other medical organizations and societies, which they eventually won a decade later.

Based on the success of osteopaths and chiropractors, other unconventional systems of medicine began clamoring for increased recognition and rights. Their cause was aided significantly by President Richard Nixon's historic visit to China in 197?, which cast a national spot light on the ancient healing systems of that country: Traditional Chinese Medicine (TCM). One TCM practice in particular—acupuncture—captured a good deal of public interest in this country (ref?). This sudden interest in acupuncture not only opened the door for other ancient healing systems of the East, including Ayurveda (the traditional system of medicine of India), but also for the other unorthodox systems of medicine in this country that had seen a steady decline over the previous century (Whorton, 1999).

The 1970s was also a time in which conventional medicine began to significantly alter its views on health and illness. There had long been a theoretical discipline within conventional healthcare, called psychosomatic medicine, which emphasized the connection between negative mental states, such as anxiety, and illness. By the late 1970s, such theories were becoming validated by sophisticated laboratory techniques, which began to document not only that negative mental states could negatively impact the immune system and physical functioning but that positive mental states could actually

protect against illness (Kiecolt-Glaser & Glaser, 1989). This newfound understanding that the mind has an ever-present role to play in physical functioning, led to the formal development of several new disciplines within conventional medicine, including psychoneuroimmunology and mind-body medicine (Whorton, 1999).

A better understanding of the mind-body connection also opened the door for conventional health care professionals to begin looking into some of the claims being made by practitioners and advocates of unconventional healthcare. In particular, the concept of the "mind as a healer," which was an integral part of many of the home-grown and imported unorthodox heath care systems in the United States, began to be viewed with a greater degree of scientific curiosity by conventional medical community rather than outright skepticism. This aspect of many unorthodox systems of health care also was particularly appealing to a growing segment of the American public, many who enthusiastically embraced these new, seemingly powerful ways of comprehending the non-physical components of health and wholeness (Whorton, 1999).

In the 1980s, as interest in and use of unconventional healthcare practices began rising dramatically in the United States (see Section I), the terminology used to describe these practices and products began to evolve. Rather than focus on what these other health care systems were not (i.e., unorthodox, unconventional, unscientific, etc.), this terminology began to focus more on what they were and how they were used.

Because it was perceived that many of these systems of health care were being used as alternatives to conventional health care, the term "alternative medicine" was widely adopted in the United States and Europe (Furnham and Smith, 1988; Murray and Shepherd, 1988). This perceptions, however, was largely dispelled by research in the late 1980's and early 1990's, which found that people were typically using the two systems of health care—conventional and unconventional—simultaneously and essentially to complement one another. In fact, research demonstrated that people used alternative health care systems and therapies because they wanted to utilize a range of therapeutic options, both alternative and conventional (Lerner & Kennedy, 1992)

As a result, the term "complementary medicine" was widely adopted not long afterwards to describe this "other" system of medicine (Ernst, 1995; Joyce, 1994). Yet, even this terminology was unsatisfactory for many because it did not take into account findings that although many alternative therapies were being used to complement conventional medical care, some were being used *instead* of conventional medical care (Astin, 1998). Thus, the phrase "complementary and alternative medicine," or CAM, has recently been adopted to acknowledge this dichotomy. This was the term used by the Office of Alternative Medicine at NIH and adopted by Congress for the NIH center on CAM in 1999.

Current Evolution of CAM

There is little doubt that some of the health care systems, modalities, and products that are commonly considered CAM are becoming more accepted not only by the public but by mainstream health care as well. Astin and colleagues (1998), for example, conducted a comprehensive review of 25 surveys of physician practices and beliefs with regard to five of the more prominent CAM systems and practices—acupuncture, chiropractic, homeopathy, herbal medicine, and massage--and found that about half of the surveyed physicians in these studies believed in the efficacy of these CAM therapies. Surprisingly, a significant proportion were both making referrals to CAM practitioners as well as offering some of the CAM treatments in their own practice.

It is not just individual doctors who have become more receptive to CAM. Indeed, over the past few years hospitals, major academic medical centers, managed care companies, and insurance carriers, have become increasingly interested in incorporating aspects of CAM into their systems. According to the American Hospital Association, for example, nearly 15.5% of America's community hospitals offered CAM services in 2000, up from about 11.1% in 1999 (AHA News, 2001). Furthermore, Pelletier and colleagues (1997) reported that a small but growing number of major medical centers are offering

CAM services. This study also found that a similar small but significant number of insurance companies are currently offering or are considering offering coverage for CAM services.

Recently, CAM has also made small, but significant inroads into mainstream medical education. A 1997-1998 survey of all 125 U.S. medical schools found that almost two thirds of those schools) that participated (117) in the survey offered elective courses in CAM or included CAM topics in required courses (Wetzel et al., 1998). Of the 123 courses reported in the survey, approximately two-thirds (68%) were stand-alone elective and the remaining constituted parts of required medical school courses. Common topics included chiropractic, acupuncture, homeopathy, herbal therapies, and mind-body techniques. Another sign that CAM is increasingly being emphasized in medical school curricula is the recent call from the American Association of Medical Colleges (AAMC) for the incorporation of knowledge about the link between spirituality and health—something that is heavily emphasized in many CAM systems of medicine-- into medical school curricula (AAMC, 1999). AAMC sees the inclusion of spirituality in the medical school curriculum as a key to promoting patient-centered health care as well as treating all aspects of the patient.

Collaboration Between CAM and Mainstream Health Care

As CAM gains an increasing foothold in the mainstream health care landscape, a number of mainstream academic heath care centers are exploring models of "integrating" CAM with modern health care practices. The ultimate goal of this integrative health care movement is to merge mainstream and CAM practices into a new, more comprehensive, compassionate, and effective model of care that includes both the precision and power of mainstream medicine and the wisdom of other healing traditions (Gordon, 1996). The underlying philosophy is to shift medicine toward healing rather than merely treating symptoms, to promote strengthened doctor-patient relationships, and increase the emphasis on mind and spirit in addition to body. According to some proponents, such an

integrated system of health care would have a strong evidence base but also would sensitive to consumer demand. (Weil, 2000).

One of the integrative models of health care that is being pilot tested at a small but growing number of mainstream medical institutions is to have mainstream and CAM practitioners working side-by-side, collaborating both in the diagnosis and treatment of patient conditions (Muscat, 2000). Although promising, this model of integration as well as others face significant obstacles, including:

- difficulty communicating,
- lack of certification and training standards for some CAM professions;
- out-of-date or hostile regulatory environments, and
- lack of insurance reimbursement

Communications Barriers

Mainstream and CAM health care practitioners often have entirely different worldviews regarding health and disease and, thus, employ a completely different vocabulary and grammar. Most mainstream practitioners have little understanding of CAM diagnostic terms, such as Qi (the Chinese term for vital energy) or doshas (the Ayurvedic term for mind-body type). Sometimes familiar terms are used but with a different meaning: acupuncturists may talk of "taking the pulse," but they will be assessing characteristics such as "wiriness" or "slipperiness," which have no Western equivalent. It is important not to interpret terms used in CAM too literally and to understand that they are sometimes used metaphorically or as a shorthand for signs, symptoms, and syndromes that are not recognized in conventional medicine.

By the same token, only a few CAM professions provide their graduates with a thorough understanding the theories and terms associated with mainstream health care, such as pathophysiology, epidemiology, molecular biology, and other sciences that conventional physicians receive training in during the medical school apprenticeships. In

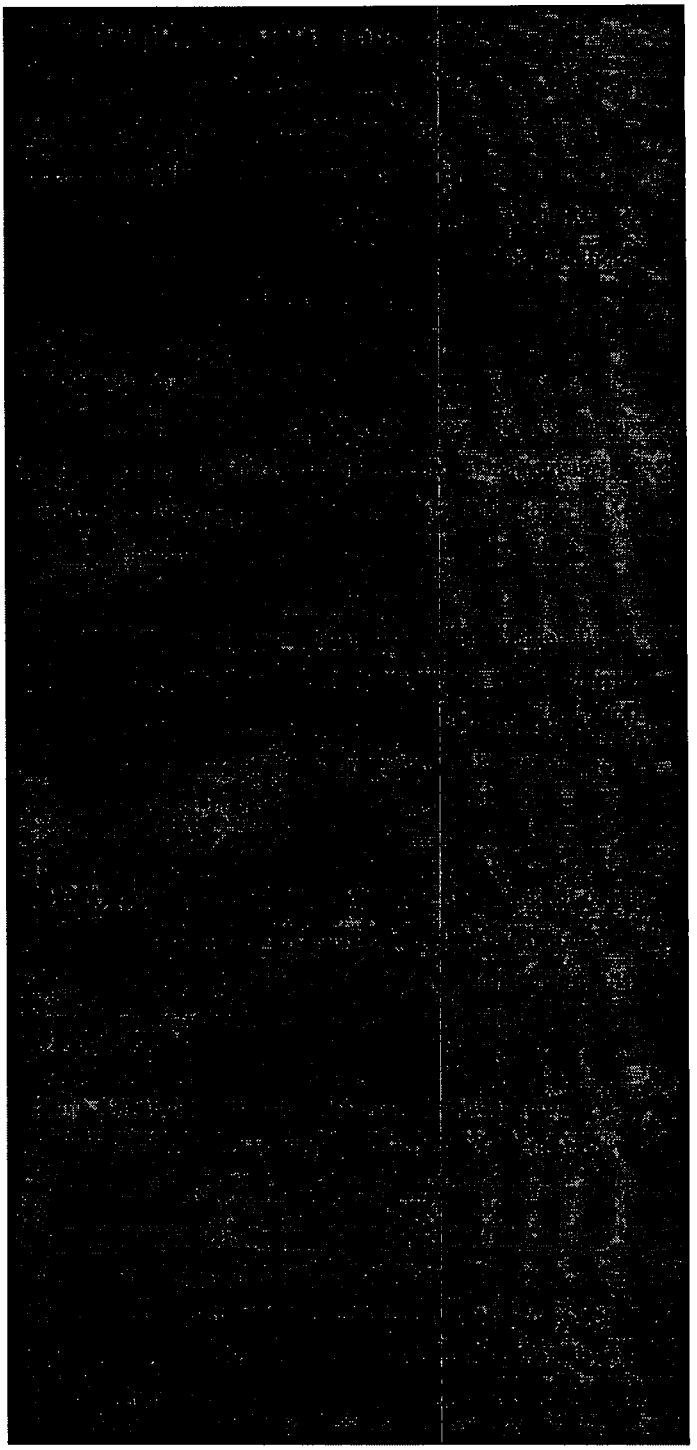
such a climate, basic communication, much less collaboration, is difficult if not impossible (Caspi et al, 2000).

Collaboration also is likely to be difficult because CAM and mainstream health care practitioners often have very different methods of assessing and diagnosing patients. A TCM practitioner may describe a patient's condition as deficiency in "liver Qi." A homeopath may describe the same condition as a "pulsatilla constitution." Whereas, the mainstream physician may describe the patients illness as "a peptic ulcer." Confusingly, there is little correlation between the different diagnostic systems: some patients with deficient liver Qi do not have ulcers, and some ulcer patients do not have deficient liver Qi but another traditional Chinese diagnosis. This could potentially cause significant problems if a CAM practitioner and mainstream doctor, working side by side, were both trying to diagnose and treat the same patient (House of Lords, 2000).

It is because of such communications barriers that many CAM systems are wary of the collaboration or integration. They believe that their collaboration with or absorption into mainstream health care may result in the loss of their independence and identity (Whorton, 1999). Although grateful and relieved that the mainstream health care is beginning embracing their ideas, approaches, and techniques, some would prefer to remain completely separate from the mainstream health care community

Licensing and Regulation Barriers

Another obstacle to integration is the lack of licensing and regulation standards for many CAM practitioners. Although some of these CAM systems lend themselves easily to certification, licensing, and regulation, others do not. There is a great diversity of education, training, and standards of practice among CAM practitioners, ranging from highly educated and organized to self-taught and unregulated (see sidebar).



Such variations in education, training, and self-regulation impact access to and delivery of CAM systems by limiting the ability of their practitioners to practice lawfully and obtain malpractice insurance. As previously mentioned, although chiropractic is licensed in all 50 states, many others are not. Acupuncturists are licensed or certified in only 32 states and the District of Columbia, and massage is licensed or certified in only 25 states. Naturopaths are only licensed or certified in 12 states, and only three states separately license homeopaths, although a number of states include homeopathy within the scope of practice of naturopaths, acupuncturists, and chiropractors. For all of the other myriad of CAM systems and approaches, there are no separate licensing and certification standards (Berman, 1999). Since insurance companies tend to cover only CAM therapies that are provided by a licensed practitioner, CAM providers that are not licensed in all 50 states find it extremely difficult to gaining access to the insurance reimbursement system (see below).

Reimbursement Barriers

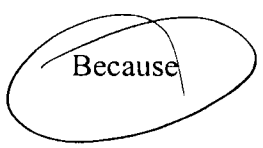
Pelletier and colleagues (1997) found that insurance carriers that do cover CAM services are not doing so to enhance wellness and prevent disease. Rather, CAM

therapies are covered only if treatment is deemed medically necessary for a specific diagnosis. Reimbursement is given only for a certain number of visits and/or dollar limit and typically only to licensed or certified CAM practitioners. Thus, lack of data proving not only efficacy for a specific condition but also cost-effectiveness compared to standard therapies is a significant barrier for CAM practitioners attempting to gain reimbursement for their services.

This creates a significant problem for many CAM providers attempting to gain insurance coverage for their patients because some CAM therapies are predominantly used as preventive medicine, and therefore cannot be easily evaluated by a disease treatment oriented system. In addition, many CAM practitioners emphasize unique, individualized treatments for each of their patients, which makes it extremely difficult to develop standards of practice guidelines (Colgate, 1995). Thus, the integration of many of these CAM approaches into mainstream health care would necessitate either a change in the CAM approach or the current mainstream health care model. Such changes are easier said than done.

Research Barriers

Related to all of the other barriers discussed above is the need for more and better research on CAM. This includes not only clinical research, but also basic science and health services research.



A major barrier to the examination of basic concepts of healing in CAM systems is that the fundamental assumptions underlying conventional Western and many CAM systems may differ. Western medicine is based on the assumption that molecular , chemical and cellular processes must be the basis for all biology and medicine. Many CAM systems assume that non-molecular processes such as energy or consciousness form foundation of life and healing. Scientists are willing to investigate the former

assumption in detail but avoid the later concepts. Resources for research funding identified as CAM at the NIH does this. For example, in 1997 over 80% of CAM dollars went to areas such as vitamin supplements, herbs and conventionally explained behavioural medicine. Less that 2% of CAM designated research dollars when for concepts such as energy, consciousness or bioelectromagnetics (ref?).

Cost effectiveness analyses are needed on individual clinically efficacious treatments as well as on combinations of mainstream and CAM treatments. Additionally, such research could compare the success of integrated CAM and mainstream approaches versus mainstream or CAM care only.

Until such research studies are conducted, the impetus for mainstream health care system to collaborate with CAM providers as well as to provide licensure and certification for CAM and reimburse for their services will be muted.

Information Dissemination Barriers

Obtaining reliable, up-to-date information on CAM has and continues to be a significant barrier for both the general public and the mainstream health care community. The quality, accuracy, accessibility, and timeliness of the information on CAM from current sources vary greatly. Even when CAM information is available, it is often difficult for the public to navigate the system to locate the desired information in a timely manner. There also is a great need for campaigns that not only that teach the public how to find and evaluate CAM information, but also hospitals, health care providers, and insurance companies who are interested in CAM. The provision of information on licensing and certification requirements also is critical, as there are numerous types of CAM providers with different levels of training and it is difficult for the public to understand the differences between them and make informed choices.

Summary

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