Kingsbury, Doris (NCCAM)

From: Similars@aol.com
Sent: Thursday, December 06, 2001 5:12 PM
To: Whccamp (NCCAM)
Subject: National Health Freedom Coalition Comment 12.6.01

Dear White House Commissioners:

I have received a copy of your draft recommendation dated 11/16/01. I was not able to attend the meeting in Washington.

On behalf of the NATIONAL HEALTH FREEDOM COALTION and NATIONAL HEALTH FREEDOM ACTION, I ask that you accept the following formal comments:

1. I commend you for your efforts in providing detailed recommendations on so many important topics to the American public. Great job.

2. I have urgent concerns regarding the following paragraphs and I URGE YOU NOT TO ADOPT PARAGRAPH 45., 47., 48., 49., 53., 54., 55., 56., 57., 58., AND 63.,

Firstly, we must not define CAM in legal terms or we will set up a new box.

Secondly, to attempt to define scope of practice for every practice in the healing arts and trades would do a grave injustice and dis-service to the art of healing.

Thirdly, practice standards are extremely different than ethical relationship standards and should not be dictated by the government but should be developed by single, or small group, or larger groups on a local level and should reflect the local and state culture of the people. Professional practices are not under the jurisdiction of the federal government and there are reasons for that constitutional premise. The States have the right to preserve their own cultures and protect their own local communities from a federalist view.

Please attempt to adopt recommendations that preserve the pluralistic and free society in which we live. Do not let special and economic interests influence your deliberations. Please support the need for consumer information and safety and stay away from language that will contribute to future turf battles and the inablity of practitioners to freely practice their trades.

Sincerely and Respectfully Submitted,

Diane Miller JD, Executive Director of National Health Freedom

Coalition.

ethics and stay away from turf battles.

Kingsbury, Doris (NCCAM)

From: Ann M. Carroll [amc11@health.state.ny.us]
Sent: Thursday, December 06, 2001 11:15 AM
To: Whccamp (NCCAM)
Subject: query

To the Commission staff:

I am a policy analyst for a New York State biomedical policy commission which is beginning a project on complementary and alternative medicine. Information from the commission, including meeting transcripts, are very helpful to us in identifying individuals and organizations with specific experinces and points of view. We would be intererested in following up with some of the persons who testified before the commission including a massage practitioner named Wayne Sickles (or Sickels) who testified at the
May 2001 meeting - there is no affiliation or address listed for him. If
this information is publicly available we would be interested in receiving
it.

Thanks,

Ann M, Carroll, Ph.D.
Senior Policy Analyst
New York State Task Force on Life & the Law
5 Penn Plaza, Rm. 301
New York, NY 10001
212/268/6714
212/268-6715 (fax)

Kingsbury, Doris (NCCAM)

From: Clay, Beth [Beth.Clay@mail.house.gov]
Sent: Thursday, December 06, 2001 10:44 AM
To: Jacqueline V. Offutt; Stephen C. Groft, Pharm.D.; Whccamp (NCCAM); Kingsbury, Doris (NCCAM)
Cc: CIA Chairman
Subject: Message from Dannion

Steve and Doris....Dannion has asked that the attached statement be copied and provided to the members of the Commission and that Jaqueline read it on his behalf during public comment. The oral statement is quite brief. He is unable to be here because he is at the hospital right now. His staff e-mailed the statement to me early today.

Thanks.*Beth Clay*
Professional Staff Member
Government Reform Committee
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515
Tel: 202-226-5867

<<decwhhcamstatement.doc>> **COMPASSION IN ACTION**

The Twilight Brigade

Statement of Dannion Brinkley

Chairman of the Board, Compassion in Action

To the

White House Commission on Complementary and Alternative Medicine Policy

December 6-7, 2001

As we end another year, it is important to see how far we have come - to look at the distance traveled. Being a part of this ongoing process, now since 1989 - literally on a daily basis because of my hospice work and my own personal issues. It is important to look for that decisive moment that will determine the point of reference this Commission will work from in making its recommendations

to the President. What is that decisive moment or point in time that crystallizes and brings us together in order to make specific recommendations on that multi-faceted, multi-dimensional world we call CAM?

I believe our President and First Lady have given us that point. In the December 3, 2001, issue of Newsweek, there is an article that I am including at the end of this testimony that I believe identifies this decisive moment.

I'll quote the most important part - it resonates with a statement the CAM community frequently asks - "What is the role of prayer in healing?"

> ***"What's the role of prayer and faith...?***
>
> ***MRS. BUSH: That's very important to us, and that's where we get our strength. But that was very important to us before September 11th, as well.***
>
> ***THE PRESIDENT: Prayer has meant a lot to me. It meant a lot to me before, it means a heck of a lot now because there's a lot of people praying for me and I feel it. Truly.***
>
> ***You know, it's something, I have never felt more confident about something in my life. And I believe a lot of it has to do with the prayers of the people."***

One of the most important, and least accepted CAM areas is the area of spirituality in medicine - of the frontier sciences. What some people call prayer, Dr. Larry Dossey calls non-local healing, and Dr. Fred Thaled calls willful conscious intent. It is an area that many of the traditional systems of medicine have accepted for thousands of years and western medicine tends to discount.

When you look at the definition of these words.
Non local healing, w con intent.
Willful - deliberate, or done by design
Conscious
Intent

And then add them into a phrase I think we find what the "heart" of healing really is. With over 400 studies on how prayer including laboratory research on the effects on yeast cultures and the power of prayer or the use of prayer, including interesting studies from Princeton showing that prayer can have an affect on the success rate of invitro fertilization. This must become a strong point in what you as a commission bring forth as recommendation to the President.

I can relate closely to the words of our President because I too have felt the results of people's prayers. Today, I cannot be with you because I am going through a series of cardiovascular and neurological procedures to first look at what is occurring to me from a conventional point of view, so that I can determine how to treat my condition from an integrative perspective. It seems as though as I am always having an up close and personal reference to modern day medical procedures either in my work or on myself.

It is the very same situation I was in a few years ago that I learned about the power of prayer first hand. My friends, the radio personality, Art Bell and his wife Ramona came to be with me as I was hospitalized in critical condition -having to go through brain surgery and having a grand mal seizure. They went on the air and on the Internet and asked the world to prayer for me. I not only felt that love and have been the beneficiary of its healing power, I know that I would not have made it through that medical crisis without the love and prayers.

I think that the President and First Lady in their recognition of the importance and power of prayer have brought a defining moment in our discussion about the need to integrate prayer/spritiuality into conventional medicine. Add to this good science which includes the work of Dr. Larry Dossey, Dr. Daniel Benor, Dr. Fred Thaled, Dr. Beverly Rubik, Dr. Wayne Jonas, Marilyn Schlitz and the Noetic Sciences, Institutes, the Templeton Foundation, and the Rockefeller Foundation, and many others and we have a point in which this entire discussion crystallizes.

Sister Charlotte is always reminding us - physical, mental, AND spiritual are all components of healing. She is correct and I think each of you truly knows this in your hearts - and I hope soon in your minds.

I continue to train my people in Compassion in Action - The Twilight Brigade that therapeutic touch and prayer are a very active part of the healing system in VA's. There is no soldier that does not know the power of prayer.

As you leave this week, one more meeting under your belt, and you head into the holiday season, please remember that prayer is not only very effective, but also quite cost effective. It takes only a little of your time to make an enormous difference in the lives of people. On a personal note, keeping all of this in mind. I ask you to pray for our servicemen and women who today are in harms way, protecting our freedoms and the responsibilities that come with being free.

And please pray for our veterans - those men and women who have already "paid it forward!" They served our country and now they need us to remember them. And also during this holiday season, think of some of the great men and women who have served this country such as Strom Thurmond, Robert Dole, Daniel Inouye, Tom Harkin, Orrin Hatch, Robert Byrd, Dan Burton, Lindsay Graham, Barbara Mikulski, and their families.

And please during this holiday season, go visit a veteran and tell them Dannion sent you!

You are all in my prayers. Happy holidays.

With Purpose,

Dannion Brinkley
Chairman of the Board
Compassion in Action

Attachments:

1: We Can Handle It
2: Pearl Harbor Press Release

PO Box 84013, Los Angeles, CA 90073 Tel: (310) 473-1941 Fax: (310) 473-1951

National Headquarters located on the campus of the West Los Angeles VA Medical Center

11301 Wilshire Blvd, Bldg 258, Room 112, Los Angeles, CA 90073

URL: <http://www.twilightbrigade.org> E-Mail: cianatl@aol.com <mailto:cianatl@aol.com> & CIAChairman@aol.com <mailto:CIAChairman@aol.com>

'We Can Handle It'

In a candid conversation, the President and First Lady talk about bin Laden, prayer, civil liberties, exercise, No. 41 and the war ahead

Dec. 3 issue - It was the day before Thanksgiving, and George and Laura Bush were flying west for a morale-boosting visit to the 101st Airborne Division at Fort Campbell, Ky. The news from Afghanistan was good and the president was in a relaxed, expansive mood for this interview. Seated at a conference table aboard Air Force One with NEWSWEEK's Howard Fineman and Martha Brant, the president and First Lady exchanged looks and smiles as they answered questions. She seemed to enjoy listening to him. As he warmed to his subjects, he sometimes raised a finger to underscore a point. Extended excerpts:

NEWSWEEK: You've talked a lot about how the country has changed. How do you think the two of you have changed as individuals?

THE PRESIDENT: I'm not very good at telling you how I've changed, because I don't spend a lot of time thinking about myself and how I've changed.

MRS. BUSH: Well, actually, I don't think he's changed that much. I think what people see now is exactly what I've always seen and always known how he was. He's very focused, he's very disciplined. I said that a million times during the campaign and I don't think it ever resonated with the press. And, of course, he's more serious-everyone is more serious in our country.

THE PRESIDENT: I don't think you change. If you've got the characteristics necessary to deal with a crisis, they will emerge. And Laura has always been a calming influence in my life and is a comfort to me as I dealt with big decisions.

You know, this is a moment of high drama, needless to say. And she couldn't have been more calm and resolved, almost placid, which was a very reassuring thing to me. I can't imagine what it would be like had Laura been hysterical, highly emotional.

There was a period of time when the threats were significant and real, aimed at me and aimed at the White House and aimed at other major targets. And during that period of time I shared some of those with Laura, never did she say, "Get me out of here, what have you done this for, why are we here, it's a miserable experience... It's your war, see you later."

Laura, may I ask, where does that calm come from?

MRS. BUSH: Well, George actually steadies me. He acts like I steady him, but the fact is he steadies me. I really am not that afraid. I mean, you know, if something happens, it happens. I think both of us have a little bit of an attitude-you know, this is our life right now and we can deal with it, we can handle it.

What's the role of prayer and faith in this?

MRS. BUSH: That's very important to us, and that's where we get our strength. But that was very important to us before September 11th, as well.

THE PRESIDENT: Prayer has meant a lot to me. It meant a lot to me before, it means a heck of a lot now because there's a lot of people praying for me and I feel it. Truly.

You know, it's something, I have never felt more confident about something in my life. And I believe a lot of it has to do with the prayers of the people.

My attitude about threats, it is truly: if it's the Lord's will. That's what I believe.

How do you keep the emotion from getting to you too much? You still have to do your job. Are there other things you turn to?

MRS. BUSH: He works out. He's really running faster than he has in a long time. He's always

turned to exercise to reduce stress.

THE PRESIDENT: I exercise about an hour a day; pretty intense these days.

Back up to a seven-minute mile?

THE PRESIDENT: Less.

MRS. BUSH: I've been working out, as well. And then the other thing we do at Camp David or at the ranch is go for long walks with our animals. And that certainly makes us feel great.

As a war leader, do you turn to any models, either in terms of time in history or people?

No question. For example, the military tribunals, you look at history. Before I made the decision to give me the option, I asked, who's done this? It's an interesting idea. I do want to have the option, for a lot of reasons-national-security reasons, security for the jurors, potential jurors.

Why did you feel it was important for you to have the authority there?

I asked for the options; I said I wanted to know. And I'm trying to remember who came in, [White House Counsel Alberto] Gonzales and the vice president, they came in to brief me. [Attorney General John] Ashcroft came in. And I said, well, tell me exactly what your recommendation is for me on this executive order. They said, well, we recommend that the secretary of Defense be the person in charge of making decisions. This is a unanimous recommendation. I was, frankly, taken aback. I said, wait a minute. I sign an executive order, I create the executive order, and somebody else is responsible for the court? I said, if I sign the order, I want to be responsible.

The flip side of that is some people say that maybe you have too much power.

I'm mindful of the Constitution. I'm also mindful of history. I think about how others have used force... I think the president needs to have the powers necessary to conduct a war. And it's up to me to make sure I provide the right balance.

Even in the face of war on our home front, we provide incredible protections for people who are not even our citizens. For people who are our citizens, nothing has changed. For people who are not citizens, who come to our country because we're an open country and a generous country, we are providing them incredible protections.

Are we going to get Osama bin Laden?

We're going to get him one way or the other.

Will it be a successful war if we don't get him?

Well, it's going to be very successful in terms of changing the government of the Taliban. We've got his number-two guy. Look, it may take three years to get Osama bin Laden, but we've got him on the run. And I've always said that this is a get-him-on-the-run mission.

But you're saying it might take three years to get Osama bin Laden.

It could take 10 years. We will get him. And we will get his organization. The thing America must know is that terrorism is alive and well. And it's our charge, our duty, this generation's historical opportunity, to rid the world of terrorism. And there's going to be some fantastic consequences from it, in my judgment. A new relationship with Russia. The ability for us to affect peace in the Middle East. Hopefully, a country like Syria will take a hard look at some of the groups in their country. And terror and weapons of mass destruction go hand in hand. To the extent that the free world can convince other nations to join together to rid the world of weapons of mass destruction, we've done our children and grandchildren a great service.

Do you think that Saddam Hussein is evil and that we should expand this to Iraq?

I think Saddam Hussein is up to no good. I think he's got weapons of mass destruction, and I think he needs to open up his country to let us inspect. I think he needs to be held accountable and needs to conform to the agreement he made years ago. That's what he ought to do. It's up to him to prove he's not.

He's the one guy in recent history who has used weapons of mass destruction not only against his neighbor, Iran, but against people in his own country. He gassed them.

Why wouldn't you say he's evil, then?

He ain't good.

Why stop short of using the word?

I think maybe because you're trying to force me to say it, and I'm stubborn... He is evil. Saddam's evil.

Have you had a moment of painful reflection? You've had to decide, for example, to use B-52 bombers, which are powerful and terrifying and which risk possible civilian casualties, et cetera.

Fifteen-thousand-pound bombs, pushed out of the back of cargo planes.

Right. Do you think that was crucial in what happened there, and was it a different level of decision-making?

I made the decision early. One, that we could win a guerrilla war with conventional means if we were able to use smart intelligence-gathering, and if we're able to get boots on the ground, to make sure our targeting was more precise.

The idea of trying to seek justice by using cruise missiles was shallow, as far as I'm concerned. It's an antiseptic approach to a war that just didn't lend itself for that. I also knew we couldn't bomb our way to achieve our objective. We could bomb our way to help achieve the objective. And, therefore, I knew full well that we would have troops on the ground.

I've been very careful to make it clear to our commanders that you're running the war, and I expect there to be conscious decisions about collateral damage. I knew full well what collateral damage could mean. I also knew we were fighting liars who would say things in the press that there was no verification for whatsoever, that they would justify their own brutal murder and torture within

their country by blaming it on us. But I had no question in my mind [we were] doing the right thing.

Is there something that you would point to where your wife has been influential? Something where tonally she's seen something outside the Beltway that maybe you hadn't?

I'll tell you this: she's not a shrinking violet. I mean, if I do something she thinks needs to be toned down or something, she'll tell me.

But I do think there was some concern that, you know, I might get carried away, because she understood how angry I was. Look, I was an angry person and I was a sad person, and I was a determined person. I went through a whole range of emotions.

What emotion did you have when you saw that plane?

I was angry. I was furious. But I had also realized that I needed to be clearsighted. I needed to understand exactly what was happening, get a feel for who was doing this, and prepare to respond.

Have you grown in any sense, do you think?
Of course. I think that I've always been the kind of person who has been able to deal with the circumstances in which I find myself. I'm a problem-solver. And I don't spend a lot of time theorizing or agonizing. I was raised in a family where, because of the love of my parents, you know, I've got confidence to be able to deal with problems. I've got a faith that allows me to be comforted by prayer and my own prayers, and prayers of others. I've never been afraid for my life, I've never been afraid for my family's life, I've never been afraid to make decisions.

[Former Bush I adviser] Brent Scowcroft says you talk to your father quite often, but you don't necessarily talk about the war. Can you tell us about that?

Yes, I talk to him, I check in with him, I'd say once a week at most. I get to work, get to the office about 6:50 a.m. to 7 a.m., and he likes to get up early. And if I've finished my paperwork, I like to give them a call and see how they're doing and just check in. He really likes it. He likes to hear from his son.

Do you talk about the substance of things, or is it just almost a melancholy thing where he's too far away from it to really deal?

THE PRESIDENT: No, I mean, he's interested as heck. He was fascinated with the Putin visit, for example. There are a lot of things I can't tell him over the phone, because it's not a secure line to his house. He says how's it going, you know, how is the war. He falls prey to the-to the spins.

MRS. BUSH: He watches every single thing. **<<...OLE_Obj...>>**

But you guys, you're not watching TV news any-you never have?
THE PRESIDENT: Not much.

Mrs. Bush, are you still reading the papers? During the campaign, you would read them and point things out to your husband.
THE PRESIDENT: She does that still.

Do you get mad, still?

THE PRESIDENT: No, she doesn't get mad, she gets pointed.

MRS. BUSH: Do I get mad?

THE PRESIDENT: She used to get mad. She got mad when she saw the budgeters had axed one of her favorite programs.

As you run the war, how important are personal relations with world leaders? And do you have nicknames for these guys?

I had better not tell you. I don't use them to their face. It is important to stay in touch with them. A lot of the leaders are coming here to sit down and visit... I think it's important for them to look me in the eye. I want them to come so they know my determination.

<<...OLE_Obj...>>

COMPASSION IN ACTION

The Twilight Brigade

Dannion Brinkley, CIA Chairman Asks Americans To Honor Pearl Harbor Day By Visiting World War II Veterans

December 5, 2001 (Los Angeles, CA,) Dannion Brinkley, Chairman of the Board of Compassion in Action today asked that all Americans honor Pearl Harbor Day by visiting World War II veterans. **"The greatest honor we can give to our World War II veterans on the 60th Anniversary of the attacks on Pearl Harbor is remember them through personal interaction. Become a regular visitor to your local VA hospital or nursing home. Become an active volunteer either through Compassion in Action - the Twilight Brigade or another of the Volunteer Service Organizations in your area."**

On December 7, 1941, we lost 2,403 members of the armed services through the attacks at Pearl Harbor. Every two days in this country that many World War II veterans die in VA facilities, nursing homes, and in private homes across the country, many with no one.

Sixty years since that day 'that will live in infamy' we have over 500,000 World War II veterans that we can not forget. These men and women grew up in a Depression went off and fought a war, came home to became the mothers and fathers of 78 million baby boomers and worked to build the greatest industrialized nation in the world. Tom Brokaw has called them 'the Greatest Generation in the history of our country' and I agree. All too often we as a nation honor the dead while not preserving and honoring the living. We must also remember those who made it back from war. We participate in programs and parades and go to see movies about World War II as a way of celebrating. The greatest way to show our gratitude for these heroes is to visit them." Brinkley stated.

Compassion in Action - The Twilight Brigade is dedicated to providing compassionate care to veterans both within Veterans' facilities and in the community. Brinkley added, "I am pleased that in four short years we have moved from 4 volunteers to over 4,000. Compassion in Action already has volunteers serving in VA facilities in 14 cities. Last year our volunteers logged over 27,000 hours at the bedside.

Compassion in Action is working to provide trained volunteers and community and professional education on end of life care. We have chapters developed or in development in 20 cities across the country. It is my dream one day to see chapters of Compassion in Action in every city in which there is a VA facility. In doing this, we will be able to work in partnership with the VA to insure that no veteran dies alone.

In the last few years there has been an increased recognition in the medical community, at the VA, and with our political leaders that end of life care can and should improve. Strom Thurman and Robert and Elizabeth Dole are among those leaders who are making a difference. Compassion in Action and its Twilight Brigade is dedicated to honoring all our veterans, especially our World War II veterans, through service.

Please visit and become an active volunteer in the VA system. It will be one of the most rewarding experiences of your life. And it is the best way Americans can show that we appreciate the love, loyalty, honor, and sacrifice these brave men and women have given to this great nation. **The heart of the Veterans Administration is the volunteer.** We need to remember the veteran. The Veterans were there when we needed them, 60 years later these veterans need us, please show them you care."

PO Box 84013, Los Angeles, CA 90073 Tel: (310) 473-1941 Fax: (310) 473-1951

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CFC Designation # 1058

# # #

Kingsbury, Doris (NCCAM)

From: Anilpatel@aol.com

Sent: Friday, April 27, 2001 6:13 AM

To: Whccamp (NCCAM)

Subject: White House Commission on Complementary and Alternative Medicine:

Mailto:WHCCAMP@mail.nih.gov
DEPARTMENT OF HEALTH AND HUMAN SERVICES, National Institutes of Health

White House Commission on Complementary and Alternative Medicine:

Congratulations are in order for holding the public hearing for the White House Commission on Complementary and Alternative Medicine (CAM).

I would like the commission to include and provide a prominent place to the Concepts, Principles and Practices of Ayurveda in all formal CAM Policies. Ayurveda would provide added strength to CAM's mission.

Ayurveda, the traditional medicine of India, is over 6000 years old and has contributed significantly to many ancient and modern medical practices through out the world. The key teaching by Ayurvedic scholars and scientists is the concept of balance and imbalance manifesting health and disease states.
Restoring balance of three "humors", namely Vata, Pitta and Kapha, involves healing the entire body rather than a few ailing organs or systems. It is the holistic approach to restoring health. Ayurvedic approaches include:
1. Concepts of Mind and Body (Yoga)
2. Cleansing and Rejuvenation (Panchkarma)
3. Preparations employing plant, animal and mineral products
4. Formulations uniquely designed to deliver specific medicament to specific sites, as exemplified by Quaths - decoctions, Bhasmas - ligands of calcinated inorganics to organic moieties, Medicated Oils and Ghees, etc.
5. Rigorous adherence to foods and diets as they are considered medicines and medicines are considered foods
6. Life style to synchronize with natural biological rhythms, exercise, hygienic rituals, cleanliness, ethical and moral practices etc
7. Unique diagnostic approaches, such as Radial Pulse Examination (Nadi Pariksha), a Non-Invasive Diagnostic Technology.

The use of Ayurveda in a complimentary role with other systems of medicines is very attractive; however, each treatment in the USA should be accepted only after proper scrutiny and evaluation. There are cultural, dietary, drug sensitivity, life style and other differences between populations that dictate a prudent approach to employ the principles of Ayurveda and work out a specific treatment for each case. There are strong paradigm differences in the way we think and how we tend to incorporate other systems. Evaluating a single plant based drug, for example, may not necessarily work in patient populations with basic constitution (Prakruti) differences, prematurely rejecting efficacious drugs from consideration. Another example would be variations in preparations that might influence efficacy. One possible approach would be to carry out comparative evaluation between populations where CAM or traditional medicine has been known to work and another population (USA) where the use is anticipated. It is obvious that there are number of factors and ramifications in adopting any system as complementary. Knowledge and evidence based approach would be crucial in accepting other systems for CAM.

Though we are searching many non-US systems to incorporate into CAM, we

should give serious consideration to products and practices native to USA (for example, contributions by Shakers, Native Americans, Polynesians, etc.). Though these may not be as ancient and time tested as Ayurveda, Chinese, European systems etc., these systems have knowledge of indigenous herbs and animal products grown in American soil and climatic conditions and have established uses for a specific cultural and ethnic group. Their use and efficacy should be evaluated for the larger US population, which is a conglomeration of such groups.

The profoundness of the principles of Ayurveda is unparalleled and well documented. Research to understand principles and use of products employing modern scientific approach, tools and techniques, are crucial for acceptance of Ayurveda and other systems. American scientists are uniquely competent to perform such investigations. The direction of such research should be not only to accumulate knowledge but also to use is efficaciously, which is more important in health related fields than others. First establish the utility and then add refinements. Such goal-oriented research should be directed towards understanding how each component (even at a molecular level) works, but more crucial would be to recognize that it works first and then why they work in concert. The approach may be likened to understand the performance of each individual instrument to create a great symphony of (holistic) music. Numerous examples can be given to support this view and many research projects could be suggested. For example without understanding what Radial Pulse Examination (Nadi Pariksha) tells us about an ailing organ and imbalance, a suggested treatment may be less or not efficacious. Then the medicinal value of the preparations and formulations must be researched employing rigorous criteria. The amounts of the active ingredient and synergistic components must be measured for quality controls and efficacious end use for the consumer rather than test animals. We may need paradigm shifts in our thinking and scientific approach, where ancient systems may provide direction.

Time and space constraints do not permit discussion in greater depth of many aspects of CAM and how the principles of Ayurveda can be incorporated.

I consider it a privilege for the opportunity to share my views.

Narayan G. Patel, Ph.D.
President and Research Director
Ayurveda Inc.,
100 E. Sutton Place
Wilmington, DE 19810-4113
(302) 475-9604

Notes:
1. Professor, University of Pennsylvania, 3624 Market Street, Philadelphia, PA. 19104, (215) 662-0867. I have taught, Ayurvedic Medicine: Concepts, Principles and Practices: a full (28 lectures and 15 hands on laboratory and field studies) course at the University of Pennsylvania.
2. I have a formal agreement with Gujarat Ayurved University, Jamnagar, India (Government of India) for Education, Research and Clinical Study collaborations.
3. Career highlights: Ph. D. (Toxicology, Biochemistry, U. of Minn), M.Sc. (Agri., Botany, Entomol.), 15 years Education Experience (U. of Minn., Case-Western Reserve,
U.of Del., U. Of Penn), adviser to MS, Ph.D and MD candidates, 20 years Industry (Du Pont-Research), Several Expeditions in Search of Medicinal Plants (India,
China, Costa Rica, USA), tested over 6500 medicinal plants and components in 40 biological systems and diseases, 20 years of Ayurvedic experience, over 100 publications, keynote speeches to three International Ayurveda and one

Acupuncture Conference, and couple of hundred lectures to schools, organizations, universities, media, video documentaries etc.

Kingsbury, Doris (NCCAM)

From: Efrain Rodriguez Malavé [eframnre@caribe.net]

Sent: Sunday, June 03, 2001 3:57 PM

To: Whccamp (NCCAM)

Subject: Public Hearings

PUERTO RICO ASSOCIATION OF NATUROPATHIC PHYSICIANS

June 19th 2001.

White House Commission on Complementary and

Alternative Medicine Policy

6707 Democracy Boulevard

Room 840, MS - 5467

Bethesda, Maryland 20892

Dear commissioners:

I would like to present to your Commission our experiences, thoughts and recommendations regarding CAM policy, since we in Puerto Rico share similar concerns and interests.

Our organization since its foundation fourteen years ago has dealt profoundly with licensing, information dissemination, education, and integration issues. Lately we've been dealing with access and research.

The experiences compiled during all these years will be of a great benefit to this Commission. For example, after thirteen years of working with the government and the legislature a law to regulate the practice of naturopathic medicine was approved in 1997. At the same time the government decided to grandfather non-formal degree practitioners with another separate regulating law, who had been practicing for several years, i.e. a "two tier system" was established. Although this might seem to be a good alternative for licensure or credentialing at a state or at a federal level, that might not be the best option, neither for the profession, the CAM movement, states and also the public health. We have the experience and the proof that this is not the best way to go.

The "two tier system" developed in Puerto Rico, has failed in assuring public protection and surely intensified the confusion. Why? Because it only took into consideration two of the three elements to be dealt with: 1) Naturopathic Physicians (N.D.) graduates of four year accredited programs at naturopathic medical schools in the U.S. 2) Medical Doctors (M.D.) with limited weekend courses or seminars in CAM modalities, without philosophy or formal training and curriculum; doing their "own thing" according to the amount of seminars taken. 3) License naturopaths (N.L.) self-educated or "graduated" from non-accredited correspondence schools. As you can appreciate the term naturopath was "awarded" to "Licensed naturopaths" because of political pressure; even more so contributing to the confusion.

P. O BOX 3659, SAN JUAN, PR 00919 (787)751-4682 – FAX 767-4148

Our experience is that licensing alone in a "two tier system" will not provoke the necessary order which this Commission is looking to obtain. Such is our conclusion from our three year experience with the "two tier system". We have knowledge of a few malpractice cases by N.L.'s .

In the case of delivery an access to CAM services, insurance coverage occasionally side-steps the only professional (N.D.) in P.R. who is fully trained in CAM. Only M.D.'s (in spite of their limited training) are being covered.

Standardization and federal guidelines are the only vehicle to promote proper education, training and licensing, as well as dissemination of proper information, access to CAM services, research on practices and products.

Another experience which may serve your purpose is the good relationship we have developed with the medical community in the integrative process. This has lead us to work together with Universidad Central del Caribe, School of Medicine, to establish the Center for Integrative and Complementary Medicine (CUMIC), where service, education, and research is been offered to the conventional and alternative medicine sectors.

We would be please to supply you with further information should you so desire.

Sincerely,

Dr. Efraín Rodríguez Malavé

President

Puerto Rico Association of Naturopathic Physicians

Kingsbury, Doris (WHCCAMP)

From: Ingrida Lusis [ILUSIS@amerchiro.org]

Sent: Monday, September 24, 2001 3:48 PM

To: Whccamp (NCCAM)

Subject: ACA comments

The following are comments of the American Chiropractic Association. A hard copy of this correspondence will follow via U.S. mail. If you have any questions regarding this correspondence, or can not open the attachment, please contact me. Thank you for the opportunity to provide the following comments.

<<affinity2.doc>>

Ingrida Lusis
Director of Government Relations
American Chiropractic Association
703/276-8800 ext 250
ilusis@amerchiro.org
www.acatoday.com

September 25, 2001

Stephen Groft, Pharm.D.
Executive Director
White House Commission on Complementary
And Alternative Medicine Policy
6706 Democracy Boulevard
Room 8800
MSC –5467
Bethesda, Maryland 20892-5467

Dear Mr. Groft:

On behalf of the American Chiropractic Association (ACA), we wish to express our concern with the Commission's discussions regarding the inclusion of affinity programs in its report to Congress as a positive example of CAM insurance coverage currently available to American consumers. The ACA, who has first hand experience in dealing with such discount programs, opposes this proposal as impeding on the ability for American consumers to receive a meaningful health care benefit from their insurance companies.

It is the view of the ACA that affinity programs confuse unsuspecting patients who may not fully understand the difference between a discount program and a covered health care benefit. Under an affinity program, the patient and the doctor assume all financial risk. The ACA is concerned that affinity programs allow health plans to eliminate and/or not incorporate chiropractic and/or CAM benefits in its core benefits package, and include it only as an add-on. The only one that benefits from affinity programs is the health insurance company. By adding this discounted product, the insurance companies can promote to customers that they have extended or added CAM coverage. This may confuse the consumer into believing that the insurance company will actually pay for CAM or chiropractic services. This is not the case. The consumer still pays out-of-pocket the discounted rate to the provider, in addition to paying the insurance company for access to the discounted product. Affinity programs do not enhance access to CAM; they mislead the consumer and include yet another barrier to access.

The ACA strongly opposes the Commission's proposal to promote affinity programs for CAM services as part of its final report to Congress. If affinity programs are made part of the report, the only victors will be the insurance companies. The financial burden will remain on the shoulders of the patient and the provider. Affinity programs **are not** the

solution in addressing the key issue of open access and reimbursement for chiropractic and/or any CAM practice – rather they are yet another deterrent to equitable coverage and reimbursement.

Thank you for the opportunity to express our concerns. If you have any questions, or require additional information, please contact Ingrida Lusis, Director of Government Relations at 703/276-8800 ext. 250.

Sincerely,

Daryl D. Wills, DC

Daryl D. Wills, DC
President

Kingsbury, Doris (NCCAM)

From: Dan Benor [danbenor@erols.com]

Sent: Thursday, November 01, 2001 10:58 PM

To: Whccamp (NCCAM)

Subject: Healing Council Recommendations amendment

Hello again Michelle,

An error was brought to my attention in my submission.

The following line:
[Diane - we should insert your website with HT and TT studies and mine as resources for the WHC]
should be replaced by
Website with Healing Touch and Therapeutic Touch studies www.healingtouch.net

Or

You can use the file attached to this one instead of the one forwarded yesterday.

Blessings and apologies for my secretarial ineptitude.

Dan

THE COUNCIL FOR HEALING
Recommendations for HEALING Research
to
The White House Commission on Complementary and Alternative Medicine
10/31/01

Background

HEALING is given in two general ways

a. The laying on of hands combined with mental intent (e.g. focus on health, meditation, prayer); and

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The laying-on of hands may be given with light touch or with the hands held near to but not touching the body. HEALING by mental intent may be given from any distance, even from many miles away (Byrd 1988; Harris et al 1999; Sicher et al 1998). This is termed, "distant HEALING."

Healer beliefs

While there is no proven theory to explain HEALING, healers suggest that HEALING effects may be mediated by biological energy fields; by the consciousness of healers and healees; by "non-local consciousness" (Dossey 1993); by discarnate consciousness (spirits, saints, Christ, Buddha); and by Divine intervention.

Theoretical research considerations

From the perspective of some healers, health would encompass a state of satisfying function, of "being in the flow" – physically, emotionally, mentally, socially, and spiritually. Others – from as wide a range of sources as traditional healers and the Vatican – suggest that health is the ability of an individual to express the purpose for which s/he has been placed on the earth. Assessments of HEALING should be consistent with a broader definition of health, not merely the treatment of disease. Biomedical indicators as measurements of health and illness do not take this into consideration, and are not adequate in operationalizing such definitions. While this may not be objectively measurable, it is an essential aspect of wellbeing that is open to assessment and should be an integral aspect of HEALING research. Qualitative aspects of transformation are as important in assessing a HEALING modality as are the quantitative measurements favored by conventional science.

Recommendations for research designs

Research should acknowledge and honor the beliefs and practices of healers. Forcing healers into a laboratory setting without factoring in the subtle nature of HEALING may lead to Type II errors (rejecting as false/non-existent a hypothesis/phenomenon that is actually true/exists). A conventional laboratory setting could, by its inherent nature, make it impossible for HEALING to be demonstrated. (A gross analogy would be to study love by asking couples to make love in a laboratory setting.)

Research settings may have subtle energies that are not conducive to HEALING.

Studying healers in their own environments, practicing in their normal fashion, is likely to be more productive. HEALING sent from a distance offers a viable compromise between scientific rigor and respecting healers' beliefs and practices. Distant HEALING offers an intervention that is eminently suitable to double-blind design.

Where the laying-on of hands is studied, a mock intervention group and a third, baseline group with no intervention are necessary in order to factor out the effects of touch, caregiver presence, and suggestion.

We are just at the start of our studies of HEALING (compared with hundreds of years with physical medicine). The complex, wholistic nature of HEALING, which may enhance functions of body, emotions, mind, relationships and spirit, with its focus on caring rather than curing, invites new ways of focusing research studies.

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Analyzing 19 experiments in which one person sought to influence another person's electrodermal activity (EDA), they found highly significant effects ($p < .0000007$).

Winstead-Fry, Patricia/ Kijek, Jean, An integrative review and meta-analysis of Therapeutic Touch research, *Alternative Therapies* 1999, 5(6) 59-67.

Out of 29 dissertation and research studies that addressed questions of efficacy, 19 showed at least partial support for the research hypothesis. The other 10 rejected the hypotheses. Deficiencies in reporting details of the studies make it very difficult to compare studies. A moderate combined effect size was found (0.39) in the 13 studies that included means and standard deviations for treatment and control groups ($p < .001$).

THE COUNCIL FOR HEALING

Participants on the Council for Healing

Daniel J. Benor, MD - Convening the Healing Council, Spiritual awareness/ HEALING, research www.WholisticHealingResearch.com

Ken Cohen, MA, MSTh - Qigong, Native American HEALING www.qigonghealing.com.

Eric Cramer, PhD - Alternate, SHEN therapy

Donald Epstein, DC - Nework Spinal Analysis www.associationfornetworkcare.com

Laurelle Gaia, International Center for Reiki Training

Rebecca Good, RN - Therapeutic Touch, Coordinator, Nurse Healers Professional Associates, Inc. www.therapeutic-touch.org

Sharon Leftwich, RN - RNReiki Connection

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Rev. Doctor Kermit Long - Alternate for Prayer Workers

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Wayne Jonas, MD - Past Director of NIH Office of Complementary and Alternative Medicine

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Mietek and Margaret Wirkus - Bioenergy practice and school

THE COUNCIL FOR HEALING
Recommendations to
The White House Commission on Complementary and Alternative Medicine
10/31/01

Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine

Definition: HEALING modalities traditionally called energy, prayer or spiritual and more recently dubbed "biofield therapies" by NCCAM. include Healing Touch, LeShan healing, Native American healing, Network Spinal Analysis, Prayer, Qigong, Reiki, Shamanic healing, SHEN Therapy, Therapeutic Touch – represented on the Council for Healing - and many other systems).

HEALING is experienced in the multiple dimensions body, emotions, mind, relationships (with other people and with the environment) and spirit. As a significant part HEALING occurs in what we term non-local consciousness (Dossey 1993), it is impossible to define HEALING in linear terminology. Words associated with HEALING may include but not be limited to: spiritual healing, quantum healing, faith healing, mental healing, psychic (psi) healing, shamanistic healing, bioenergetic healing. subtle energy healing, vibrational healing, divine healing, unconventional healing, paranormal healing, distant mental influence on living systems (DMILS), non-local consciousness healing.

Background: HEALING is a gift that everyone has to some degree. Most caregivers have this ability, though in many it may be expressed outside of their conscious attention (Benor 1993). *Learning is best done through mentoring, as the awareness of subtle biological energies and intuitive awareness are impossible to translate fully or even adequately into linear explanations and words.* Training can enhance this ability and education can increase assurance that the gift will be used judiciously and professionally.

Certification courses are offered in some of the HEALING modalities, including Healing Touch, LeShan healing, Network Spinal Analysis, Qigong, Prayer workers, Reiki, some Shamanic healing, SHEN Therapy, Therapeutic Touch and others. Certification is considered irrelevant or inappropriate in most Native American, Shamanic and prayer traditions.

There is no licensure for HEALING.

While clinical and laboratory effects of HEALING have been amply demonstrated in close to 200 studies on humans, animals, plants, bacteria, yeasts, cells in vitro, enzymes, and DNA (Benor 2001a, b), HEALING as a therapy is impossible to measure – in the processes of giving and receiving HEALING to individuals - except by outcome or subjective experience.

Accountability is very difficult to establish, due to the inability to measure directly clinical HEALING effects, except by outcome or subjective reports.

Healers observe that HEALING can bring about improvements in body, emotions, mind, relationships (with other people and with the environment) and spirit. HEALING enhances wellbeing, and in surveys of healees is rated helpful in 80 to 91 percent of those questioned (Benor 2001a; 2001b).

HEALING is a gift, and the practice of HEALING is an art as much as a therapy. Because HEALING is such a widespread gift, and is often a part of many other therapies (frequently unrecognized and often outside the awareness of the participants), it has often been impossible to separate out from the other therapies (Benor 1995). Many conventional and CAM health, wellness and therapeutic modalities involve HEALING techniques, intuitive assessments, and biofield applications that sometimes are not defined or even identified as parts of the specific discipline. HEALING may be an aspect of therapies offered by conventional licensed practitioners, as well as by traditional and CAM therapists and by non-licensed, uncertified, untrained practitioners. As a phenomenon which has been largely ignored (and sometimes even disparaged) by most regulated disciplines, it has been a loss to the public sector and to the practitioners. Practitioners of all disciplines and approaches need to have a group which represents the phenomena of HEALING, to include what has been considered the art of clinical practice, but which HEALING practitioners have honed into a variety of defined treatment modalities. The Council for Healing wishes to state emphatically that HEALING, be it associated with client assessment, treatment, care, wellness coaching or "holding the space" for HEALING or "thy will be done" needs a voice, a common lexicon, a research agenda, and a rightful place in the culture and science of health care.}

The professional development and conduct of healers is best assessed by peer supervision and review.

The Council for Healing recommends that the practice of HEALING should not be regulated by law.

References:

Benor, Daniel J, Spiritual healing: a unifying influence in complementary therapies, *Complementary Therapies in Medicine* (UK), 1995, 3(4), 234-238, http://www.wholistichealingresearch.com/Articles/Unifying.htm .

Benor, Daniel J, *Healing Research: Volume I, Spiritual Healing: Scientific Validation of a Healing Revolution*, Southfield, MI: Vision Publications, 2001(a).

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Recommendations for research designs

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Schlitz, Marilyn/ Braud, William, Distant intentionality and healing: assessing the evidence, *Alternative Therapies* 1997, 3(6), 62-73.

Analyzing 19 experiments in which one person sought to influence another person's electrodermal activity (EDA), they found highly significant effects ($p < .0000007$).

Winstead-Fry, Patricia/ Kijek, Jean, An integrative review and meta-analysis of Therapeutic Touch research, *Alternative Therapies* 1999, 5(6) 59-67.

Out of 29 dissertation and research studies that addressed questions of efficacy, 19 showed at least partial support for the research hypothesis. The other 10 rejected the hypotheses. Deficiencies in reporting details of the studies make it very difficult to compare studies. A moderate combined effect size was found (0.39) in the 13 studies that included means and standard deviations for treatment and control groups ($p < .001$).

THE COUNCIL FOR HEALING

Participants on the Council for Healing

Daniel J. Benor, MD - Convening the Healing Council, Spiritual awareness/ HEALING, research www.WholisticHealingResearch.com

Ken Cohen, MA, MSTh - Qigong, Native American HEALING www.qigonghealing.com.

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Rev. Doctor Kermit Long - Alternate for Prayer Workers

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Stanley Krippner, PhD - Shamanism

Wayne Jonas, MD - Past Director of NIH Office of Complementary and Alternative Medicine

Diane Miller, Esq. - CAM legislation

Mietek and Margaret Wirkus - Bioenergy practice and school

THE COUNCIL FOR HEALING
Recommendations to
The White House Commission on Complementary and Alternative Medicine
10/31/01

Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine

Definition: HEALING modalities traditionally called energy, prayer or spiritual and more recently dubbed "biofield therapies" by NCCAM. include Healing Touch, LeShan healing, Native American healing, Network Spinal Analysis, Prayer, Qigong, Reiki, Shamanic healing, SHEN Therapy, Therapeutic Touch – represented on the Council for Healing - and many other systems).

HEALING is experienced in the multiple dimensions body, emotions, mind, relationships (with other people and with the environment) and spirit. As a significant part HEALING occurs in what we term non-local consciousness (Dossey 1993), it is impossible to define HEALING in linear terminology. Words associated with HEALING may include but not be limited to: spiritual healing, quantum healing, faith healing, mental healing, psychic (psi) healing, shamanistic healing, bioenergetic healing. subtle energy healing, vibrational healing, divine healing, unconventional healing, paranormal healing, distant mental influence on living systems (DMILS), non-local consciousness healing.

Background: HEALING is a gift that everyone has to some degree. Most caregivers have this ability, though in many it may be expressed outside of their conscious attention (Benor 1993). *Learning is best done through mentoring, as the awareness of subtle biological energies and intuitive awareness are impossible to translate fully or even adequately into linear explanations and words.* Training can enhance this ability and education can increase assurance that the gift will be used judiciously and professionally.

Certification courses are offered in some of the HEALING modalities, including Healing Touch, LeShan healing, Network Spinal Analysis, Qigong, Prayer workers, Reiki, some Shamanic healing, SHEN Therapy, Therapeutic Touch and others. Certification is considered irrelevant or inappropriate in most Native American, Shamanic and prayer traditions.

There is no licensure for HEALING.

While clinical and laboratory effects of HEALING have been amply demonstrated in close to 200 studies on humans, animals, plants, bacteria, yeasts, cells in vitro, enzymes, and DNA (Benor 2001a, b), HEALING as a therapy is impossible to measure – in the processes of giving and receiving HEALING to individuals - except by outcome or subjective experience.

Accountability is very difficult to establish, due to the inability to measure directly clinical HEALING effects, except by outcome or subjective reports.

Healers observe that HEALING can bring about improvements in body, emotions, mind, relationships (with other people and with the environment) and spirit. HEALING enhances wellbeing, and in surveys of healees is rated helpful in 80 to 91 percent of those questioned (Benor 2001a; 2001b).

HEALING is a gift, and the practice of HEALING is an art as much as a therapy. Because HEALING is such a widespread gift, and is often a part of many other therapies (frequently unrecognized and often outside the awareness of the participants), it has often been impossible to separate out from the other therapies (Benor 1995). Many conventional and CAM health, wellness and therapeutic modalities involve HEALING techniques, intuitive assessments, and biofield applications that sometimes are not defined or even identified as parts of the specific discipline. HEALING may be an aspect of therapies offered by conventional licensed practitioners, as well as by traditional and CAM therapists and by non-licensed, uncertified, untrained practitioners. As a phenomenon which has been largely ignored (and sometimes even disparaged) by most regulated disciplines, it has been a loss to the public sector and to the practitioners. Practitioners of all disciplines and approaches need to have a group which represents the phenomena of HEALING, to include what has been considered the art of clinical practice, but which HEALING practitioners have honed into a variety of defined treatment modalities. The Council for Healing wishes to state emphatically that HEALING, be it associated with client assessment, treatment, care, wellness coaching or "holding the space" for HEALING or "thy will be done" needs a voice, a common lexicon, a research agenda, and a rightful place in the culture and science of health care.}

The professional development and conduct of healers is best assessed by peer supervision and review.

The Council for Healing recommends that the practice of HEALING should not be regulated by law.

References:
Benor, Daniel J, Spiritual healing: a unifying influence in complementary therapies, *Complementary Therapies in Medicine* (UK), 1995, 3(4), 234-238, http://www.wholistichealingresearch.com/Articles/Unifying.htm .
Benor, Daniel J, *Healing Research: Volume I, Spiritual Healing: Scientific Validation of a Healing Revolution*, Southfield, MI: Vision Publications, 2001(a).
Benor, Daniel J, *Healing Research: Volume I, Professional Supplement*, Southfield, MI: Vision Publications, 2001(b).
Dossey, Larry, *Healing Words:* New York: HarperSanFrancisco 1993
Randall-May, Cay, *Pray Together Now: How to find or Form a Prayer Group*, Boston, MA: Element 1999.

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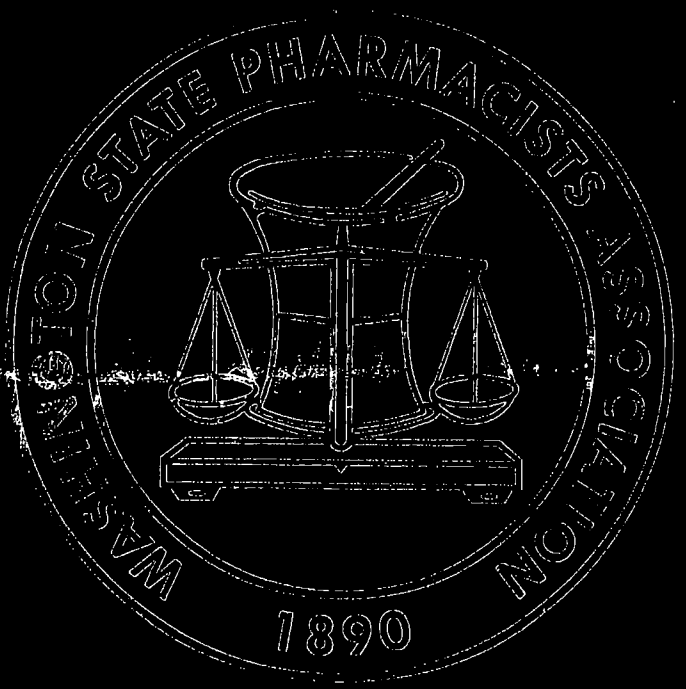
WASHINGTON STATE PHARMACISTS ASSOCIATION
1890

White House Commission on Complementary and Alternative Medicine Policy

Testimony by:

Donald F. Downing R.Ph.
Washington State Pharmacists Association
1501 Taylor Ave SW
Renton, WA 98055

October 31, 2000

Good afternoon, my name is Don Downing and I represent the Washington State Pharmacists Association today. I want to thank Director Groft and the White House Commission for this opportunity to speak to the issues related to Complementary and Alternative Medicine. I have spent most of my professional career as a pharmacist providing care for the urban underserved at the Seattle Indian Health Board clinic and for the Puyallup Indian Tribe.

I am concerned that the most accessible, most often visited health care professional in the United States –the pharmacist – is not being acknowledged as a CAM provider, nor recognized by the Federal Government, as an allopathic health care provider. Our health care interventions result in the savings of billions of health care dollars and the improvement of the quality of life for millions of Americans.

The quality and cost-effectiveness of pharmacist monitoring and co-management of chronic medical conditions such as asthma, diabetes, dyslipidemias, hypertension, pain and depression, among other maladies are well documented in the medical literature. Pharmacists also provide needed preventative services such as influenza, pneumococcal and hepatitis immunizations. We use behavioral modification techniques and education to help people end their tobacco usage and to help manage their nutrition, weight and improve their level of physical activity and ultimately their quality of life.

Even in Washington State where we are fortunate enough to have the "Every Category of Provider Law," it has been an uphill struggle to have pharmacists invited to the table. Up until now, the efforts by the Washington State Office of the Insurance Commissioner have not included pharmacists – even though this law speaks to access to "any category of provider licensed by the state of Washington." Yesterday's testimony by the Insurance Commissioner's office, failed to mention pharmacists even though we are licensed health care providers in the State of Washington and have worked for months to be recognized as such under this law. How ironic that a state that is so progressive has

repeatedly positioned the pharmacy profession in a state of purgatory between CAM and allopathic practice.

The perception is that pharmacists count and pour pills. The reality is that they are university-trained for a minimum of 6 years in the treatment and management of the whole patient. We are well positioned to assist in the co-management of patients taking herbal as well as other treatments and to refer patients to other providers for comprehensive care.

A health system that compensates such a highly skilled and accessible provider of health care only when they sell another prescription is missing an opportunity to provide accessible, cost-effective care. We have the training, the research, the licensure and accountability, but not the recognition and compensation incentive to provide care to the underserved and poorly served.

Patients deserve to have access to our country's medication experts. I would ask three things of this commission:

1. Include pharmacists in all your discussions and decisions related to complementary and alternative medicine.
2. Assist the profession of pharmacy in being recognized by the Federal Government as a health care provider
3. Take the message home that pharmacists are complementary providers, well positioned to help integrate the best of CAM and allopathic care.

Thank you,

Don Downing
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dondown@u.washington.edu

Disease Management – Studies on the benefits of disease management services for the treatment of asthma

Effects of an Asthma Management Program on the Asthmatic Member: Patient-Centered Results of a 2 year Study in a Managed Care Organization.

Buchner DA, Butt LT, De Stafano A, Edgren B, Suarez A, Evans RM
American Journal of Managed Care, 1998;4(9): 1288-1297.

Key Results: Knowledge about asthma and health-related quality of life improved; percentage of patients with claims for an inhaled corticosteroid increased; rate of inpatient hospitalizations declined; ER visits were unchanged.

Economic evaluation of pharmacist involvement in disease management in a community pharmacy setting.

Munroe WP, Kunz K, Dalmady-Israel C, Potter L, Schonfeld WH.
Clinical Therapeutics. 1997;19:113-123

Key Results: Decrease in monthly medical costs by $293 per person despite an increase in prescription costs.

Pharmacist-managed, physician-directed asthma management program reduces emergency department visits.

Pauley TR, Magee MJ, Cury JD.
Annals of Pharmacotherapy. 1995;29:5-9

Key Results: Reduced ER visits from 47 to 6. The time period studied was 6 months after start of intervention compared with same 6-month period for previous year and also 6-month period before intervention.

Developing and marketing a community pharmacy-based asthma management program.

Rupp MT, McCallian DJ, Sheth KK.
Journal of the American Pharmaceutical Association. 1997;NS37:694-699

Key Results: Decrease in hospitalization (77%), ER visits (78%), urgent care visits (25%); the HMO renewed its contract for the program, which was expanded to include 40 patients.

The economics of an intensive education programme for asthmatic patients.

Sondergaard B, Davidsen F, Kirkeby B, Rassmussen M, Hey H.
PharmacoEconomics. 1992;1:207-212

Key Results: No difference between the patient education groups and the control group in number of admissions and readmissions to the hospital; cost of drugs, appropriateness of drug therapy, adherence, quality of life, and health status higher in the education group; number of days lost lower in the education group; unclear cost-benefit analysis.

Disease Management – Studies on the benefits of disease management services for the treatment of diabetes

Management of patients with type 2 diabetes by pharmacists in primary care clinics.

Coast-Senior EA, Kroner BA, Kelley CL, Trilli LE
Ann Pharmacother: 1998;32:636-41

Key Results: Pharmacists' efforts as part of a multidisciplinary team improved glycemic control significantly in patients with type 2 diabetes who require insulin.

Evaluation of a clinical pharmacist in caring for hypertensive and diabetic patients.

Hawkins DW, Fiedler FP, Douglas HL, Eschback RC
Am J Hosp Pharm. 1979;36:1321-1325

Key Results: Care provided by the clinical pharmacist and care provided by the physician were equivalent in controlling blood glucose and diastolic blood pressure. The kept-clinic-appointment rate was higher and the clinic dropout rate was lower in the experimental group (pharmacist managed care) compared with the control group (pharmacist managed care) compared with the control group (physician-managed care), suggested greater patient satisfaction with care provided by the clinical pharmacist.

Pharmacist-managed diabetes education service.

Huff PS, Ives TJ, Almond SN, Griffin NW
Am J Hosp Pharm. 1983;40:991-4

Key Results: Pharmacists were able to provide more instructional time than typically is provided by physicians, thereby improving patient understanding. Patients were grateful to have ready access to pharmacists for information or help solving problems. Physicians had more time available to spend with other patients once pharmacists assumed the patient education responsibility. Communication between pharmacists and physicians improved.

Evaluation of pharmaceutical care model on diabetes management.

Jaber LA, Halapy H, Fernet M, Tummalapalli S, Diwakaran H.
Ann Pharmacother: 1996;30:238-43

Key Results: A comprehensive model of pharmaceutical care effectively improved glycemic control, but not blood pressure, lipid levels, body weight, or measured quality-of-life parameters, in a clinic-based population of urban African American patients with type 2 diabetes. Changes in glycemic control were attributed to improved patient understanding of diabetes and optimization of oral hypoglycemic regimens.

Pharmacists' interventions using an electronic medication-event monitoring device's adherence data versus pill counts.

Matsuyama JR, Mason FJ, Jue SG.
Ann Pharmacother: 1993;27:851-855

Key Results: The MEMS data allowed pharmacists to individualize recommendations to a greater extent than the pill count method.

Asheville Diabetes Project

See References listed on attached document

Patient Satisfaction of Asheville Diabetes Project
Key Results:

- Overall patient satisfaction with the pharmacist, pharmacists' explanation of drug therapy, technical competence and courteousness of staff improved over baseline.
- Quality of life showed a significant improvement in general health perception, energy, emotional status, pain and physical function over baseline.
- Asheville Diabetes Project has grown from 38 patients to 60 patients with about 1 additional patient per month.

Clinical and Economic Outcomes
At 14 months, 85% of patients showed at least some improvement of hemoglobin A1c values. The mean improvement was 1.4%. This improvement of hemoglobin A1c results in a decreased risk of up to 63% for retinopathy, 60% for neuropathy, and 54% for albuminuria.

- Patient-provider interactions increased (ie. Less in-patient acute care needs)
- Shift of services from inpatient to outpatient
- Sick leave decreased by 47.6%
- Payer incurred total one-time start-up costs of $262 per diabetic patient for blood glucose monitors and diabetes education by diabetes education center.
- Average pharmacist reimbursement of $30-$38 per follow-up visit (about $1 per minute)

Issues in Medication Use in the United States

Issue:

The costs to our health care system from drug-related problems easily surpass costs related to diabetes and obesity, and are rapidly approaching those related to cardiovascular disease (see graph). Studies show that billions of dollars would be saved each year, and quality of care would be improved, if pharmacists and pharmaceutical care were utilized properly to reduce incorrect medication use and medication errors.

Discussion:

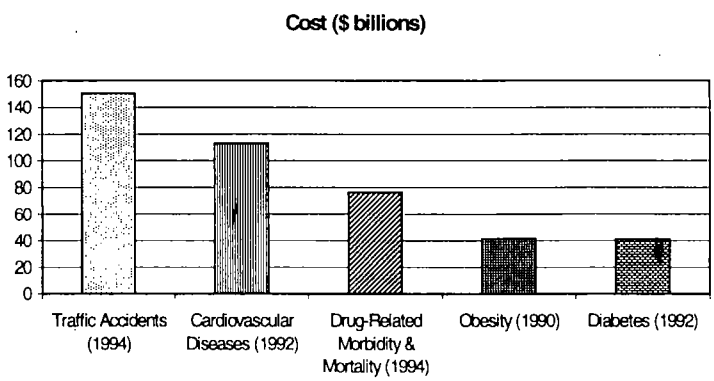
As health care costs spiral out of control and public tolerance dwindles, policy makers must make tough decisions about how to manage health care costs. Many of these decisions, however, are hugely unpopular with the American public when they perceive that their quality of care is being compromised. The dilemma, then, is to manage health care costs in ways that will improve quality of care while gaining public acceptance.

Recent in-depth studies in the field of pharmacy have unearthed startling statistics that clearly indicate that the above criteria can be met. In a landmark initiative called The Fleetwood Project, a comprehensive approach to examine patient outcomes and the cost of drug-related problems, the following conclusions were reached:

- Americans pay more for drug-related problems than they do for the drugs themselves. For every $1.00 spent on drugs in nursing facilities, $1.33 in healthcare resources are consumed in the treatment of drug-related problems;
- Patients who receive enhanced pharmaceutical care in nursing facilities have increased optimal outcomes of more than 40%: and
- With current federally mandated drug regimen review, it is estimated consultant pharmacists help to reduce healthcare resources due to drug-related problems in nursing facilities by $3.6 billion.

In addition, a study published in 1995 in the **Archives of Internal Medicine** states that:

- Drug-related morbidity and mortality in the ambulatory setting costs $76.6 billion. If consistent drug therapy management is provided. ***$45.6 billion could be saved - a cost reduction of 59.6%.*** If lost productivity costs are factored in with the health care costs, the $76.6 billion figure would increase to $138 to $182 billion;
- Greater than 16% of all hospital admissions in the U.S. result from drug-related problems, with those admissions related to medication noncompliance having direct costs of $8.5 billion; and
- In terms of resources consumed, these drug-related morbidity and mortality costs are in the same cost range as many of the major public health issues or diseases, leading many to suggest that drug-related problems should be considered a major category of disease.



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Americans want to believe that there are medications to cure all ills. With so many strides being made in the pharmaceutical industry today, it is easy to understand why consumers feel this way. Over the past 30 years, the number of prescription medications available has increased from around 650 to nearly 10,000. Advances in pharmaceutical therapy often allow this form of treatment to replace more invasive and costly procedures and technologies such as surgery.

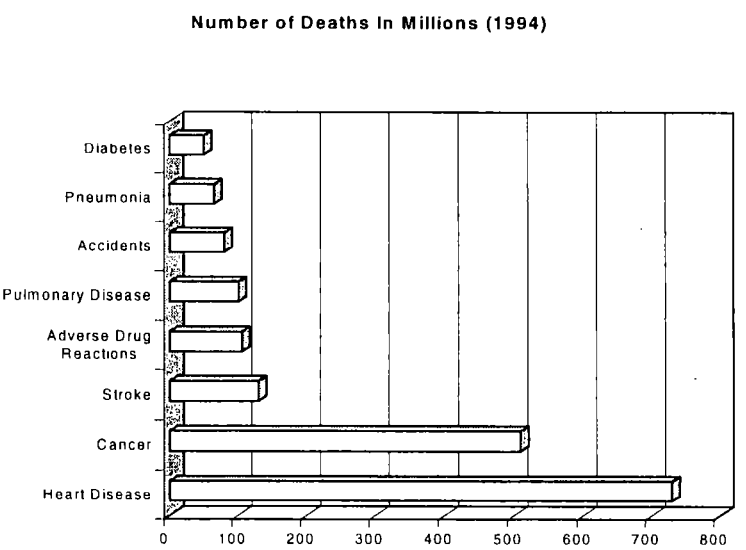
However, it is a little-known fact that drug-related problems frequently occur, often with costly or devastating effects. Drug-related problems include:

- failing to obtain a necessary prescription for a medical condition
- taking the wrong medication
- taking too little or too much of a medication
- failing to take a prescribed medication
- experiencing adverse effects as a result of a prescribed drug
- experiencing adverse effects as a result of a drug/drug, drug/food or drug/laboratory interaction
- taking a medication for no medically valid reason

A study published in the April 1998 Journal of the American Medical Association (JAMA) identifies adverse drug reactions (ADRs) as an important clinical issue, even when drugs are properly prescribed and administered. Estimates reveal that 106,000 hospital patients died in 1994, ranking ADRs as the fourth leading cause of death. Furthermore, the study suggests that ADRs could be responsible for an additional $1.56 billion to $4 billion in direct hospital costs per year, costs that are related to both fatal ADRs and nonfatal ADRs, of which 2.2 million were estimated in 1994. The study excluded errors related to administration, more commonly known as medication errors. As an increasingly reported problem, medication errors can also have costly consequences, and should be viewed as a significant public health issue.

Solution:

Pharmacists are highly educated, yet currently underutilized, in monitoring patients for the many factors that can lead to drug-related problems. As such, they should be fully integrated participants on the patient's healthcare team in all practice settings for the purpose of achieving optimal outcomes and cost savings. Policy makers can have a direct and dramatic impact by recognizing the value of enhanced pharmaceutical services and working to make them more widely available. Studies show that increased use of pharmaceutical services will lead to significant cost savings in our health-care system.



Pharmacists' Services Can Save Medicaid $7.5 Billion Annually Nationwide

A frequently cited, cost-of-illness analysis conducted in 1995 estimated that drug-related morbidity and morality among ambulatory patients costs the U.S. economy $76.6 billion annually in direct costs alone (Arch Intern Med 1995; 155:1949-1956). Current estimates that include both long-term care and hospital care put these costs at $100 billion. These costs resulted from incremental utilization of health care services for physician, urgent care, or emergency department visits; hospital or long-term care admissions; or additional medications when patients received less-than-optimal outcomes from their prescription medicines. A follow-up analysis suggested that $45.6 billion could be saved annually if pharmacists are more fully enabled to provide comprehensive pharmaceutical care for these ambulatory patients. (Am J Health Syst Pharm 1997;54:554-558; Arch Intern Med 1997; 157:2089-2096; JAMA 1997; 277 no. 4: 307-311.)

Of special interest is the cost that drug-related morbidity and mortality represents to the nation's-and individual state's Medicaid programs. In 1997, prescription drug payments for Medicaid beneficiaries in the U.S. totaled nearly $12 billion. Extrapolating from the $76.6 billion spent nationwide on drug-related morbidity and mortality, an estimated $12.7 billion was incurred on such expenses by Medicaid that year. The current analysis suggests over 30 states may very well spend more each year on managing drug-related morbidity and mortality than they do on prescription medications themselves. ***Washington is one of these states.***

This analysis also suggests that pharmacists could save approximately $7.3 billion annually within Medicaid programs alone through activities like drug therapy and disease-state management. Cost savings are achievable within all 50 states. Within individual states, these estimated savings range from $4.3 million in Rhode Island to $904 million in California. ***Washington State's estimated net savings is $97,473,611***

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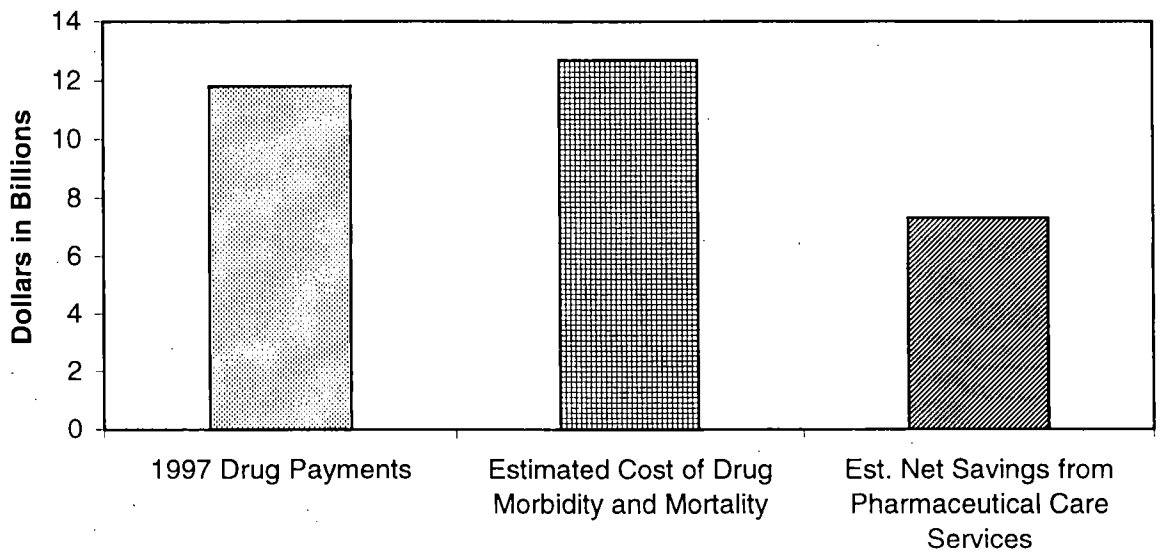
Potential Savings to State Medicaid Programs if Comprehensive Pharmacy Services are Universally Available



Potential Savings to State Medicaid Programs if Comprehensive Pharmacy Services Were Universally Available

State	1997 Drug Payments	Estimated Cost of Drug Morbidity and Mortality	Estimated Net Savings from Pharmaceutical Care Services
Alabama	$226,105,163	$210,156,779	$120,312,526
Alaska	$28,376,842	$77,822,429	$41,970,591
Arizona	$1,855,572	$49,188,187	$25,017,110
Arkansas	$135,767,334	$207,619,708	$118,810,590
California	$1,335,066,753	$1,533,777,170	$903,895,798
Colorado	$96,964,173	$97,035,892	$53,344,901
Connecticut	$166,667,301	$110,897,624	$65,551,107
Delaware	$34,713,581	$20,206,002	$7,861,668
Dist. of Columbia	$37,512,355	$28,798,513	$12,948,483
Florida	$772,760,639	$932,039,487	$547,687,089
Georgia	$339,257,021	$769,045,795	$451,174,824
Hawaii	$26,854,246	$44,711,513	$22,368,928
Idaho	$45,042,165	$65,570,094	$34,717,209
Illinois	$523,581,885	$456,943,729	$266,410,401
Indiana	$293,318,000	$268,183,961	$154,664,618
Iowa	$123,861,339	$111,962,751	$62,181,661
Kansas	$104,628,978	$75,276,545	$40,403,428
Kentucky	$316,464,180	$319,957,934	$185,314,810
Louisiana	$315,440,010	$374,363,783	$217,523,072
Maine	$102,537,198	$31,364,680	$14,467,603
Maryland	$172,701,280	$159,287,968	$90,198,190
Massachusetts	$398,076,067	$309,452,721	$179,095,724
Michigan	$365,282,227	$341,904,444	$198,307,144
Minnesota	$158,830,088	$207,772,618	$115,901,100
Mississippi	$208,577,199	$311,855,757	$180,518,321
Missouri	$320,680,206	$108,667,950	$60,231,139
Montana	$35,170,912	$55,037,443	$28,481,879
Nebraska	$79,727,194	$85,562,367	$46,552,035
Nevada	$26,852,299	$76,445,963	$41,155,723
New Hampshire	$45,361,700	$32,884,637	$15,367,418
New Jersey	$369,839,049	$158,461,478	$89,708,908
New Mexico	$83,345,890	$146,680,516	$82,734,579
New York	$1,090,917,486	$641,918,670	$375,915,566
North Carolina	$403,811,339	$563,228,692	$329,331,099
North Dakota	$25,226,544	$22,864,520	$9,435,508
Ohio	$580,582,988	$504,863,491	$294,778,800
Oklahoma	$110,880,182	$113,285,371	$62,964,652
Oregon	$73,216,763	$50,757,702	$25,048,272
Pennsylvania	$552,266,949	$357,841,582	$207,741,930
Rhode Island	$52,186,739	$14,219,697	$4,317,774
South Carolina	$159,000,414	$230,564,759	$132,394,050
South Dakota	$27,591,466	$35,881,211	$17,141,390
Tennessee	$1,118	$247,340,968	$142,325,566
Texas	$750,056,208	$1,280,729,942	$701,091,038
Utah	$50,825,675	$46,074,438	$23,175,780
Vermont	$44,291,004	$26,038,683	$11,314,613
Virginia	$249,620,903	$328,359,632	$190,288,734
Washington	**$204,980,309**	**$171,577,531**	**$97,473,611**
West Virginia	$133,044,883	$208,989,303	$119,621,380
Wisconsin	$205,503,614	$68,236,316	$36,285,612
Wyoming	$14,264,016	$32,065,939	$14,882,749
Total	$11,972,331,192	$12,736,352,820	$7,324,906,494

Pharmaceutical Benefits Under State Medical Assistance Programs 1998. National Pharmaceutical Council, pgs. 4-19. Drug-related morbidity and mortality in ambulatory patients in the US has been estimated to cost 576.6 billion annually, or approximately $114 per physician visit (Arch Intern Med 1995;155:1949-1956). Based on the number of outpatient physician visits, the direct cost for drug-related morbidity and mortality in ambulatory Medicaid beneficiaries is estimated for each state. Provision of comprehensive pharmacy services as described in the accompanying materials, could reduce the total U.S. cost of drug-related morbidity and mortality in ambulatory patients by $45.6 billion annually, or approximately $68 per physician visit (Am J Health Syst Pharm 1997;54:554-558). Based on the number of outpatient physician visits, the direct cost savings is estimated for each state.

Innovative Pharmacists Can Improve Care and Reduce Health Care Costs

Value of the Pharmacist

The pharmacist has a responsibility to prevent, identify, and resolve potential and actual drug-related problems. A pharmacist also has a role in recommending effective medications, educating other providers about appropriate drug therapy, and counseling patients so they understand proper medication requirements. A drug regimen review is the process where a pharmacist analyzes each prescription to optimize drug therapy and minimize drug-related problems. In a nursing home setting, federal law requires that each resident receive the services of a consultant pharmacist, including drug regimen review, at least monthly. A recent study published in the Archives of Internal Medicine found that consultant pharmacist-conducted drug regimen review improves optimal therapeutic outcomes by 43% and saves as much at $3.6 billion annually in costs associated with drug-related problems.

Collaborative Drug Therapy: Pharmacists Working with Health Care Team

Enhancing the way health care is delivered ultimately results in improved quality for the patient and increased savings for the health care system. One way this is achieved is through collaborative drug therapy management, where a physician and a pharmacist enter into a written agreement to manage the drug therapy of a particular patient.

Currently, 21 states **including Washington,** recognize that pharmacists may work with physicians to initiate, modify or discontinue drug therapy, perform physical assessments, order laboratory tests, and provide other services to manage the drug therapy of patients. An additional 22 states are currently developing or reviewing proposals to provide for pharmacist and physician collaborative practice agreements.

Many other states have realized that collaborative drug therapy management improves overall patient care by allowing pharmacists to assist other health professionals by offering their assessment of a patient's drug use and drug therapy.

Pharmacists in Washington are also involved as part of the health care team in several retail, hospital, hospice, and home health care settings. These services include:

Anticoagulation Therapy: Expanding in Washington and the nation due to the fact that only 40% of patients who need this therapy are currently receiving it. So, in an effort to control clotting and bleeding problems that often result in hospitalization, pharmacists are work with other health care practitioners in providing this care. It is estimated that as much as $1,400 per year per patient can be saved by this collaborative care.

Pain Management: Patients, pharmacists, nurses, and doctors are partnering to provide safe and effective pain control to patients. This management ensures better quality of treatment, during periods where patients are receiving care for underlying causes or during chronic or life-threatening illness. Pharmacists believe this collaborative care will prevent worsening illness and costly emergency room visits and other acute care.

Pharmaceutical Care

Pharmacists are uniquely trained to provide the component of the health care system known as pharmaceutical care. Pharmaceutical care activities involve the collaboration of the pharmacist with physicians, nurses, and other health care professionals to ensure medications are used appropriately to improve patient health, improve a patient's quality of life, and contain health care costs.

Pharmacists in Washington launched "Cognitive Activities and Reimbursement Effectiveness" (CARE) in 1996. This project was initiated to test a payment system for pharmaceutical care services provided by pharmacist to Medicaid patients in addition to the standard dispensing fee. Targeting principally the most vulnerable patients, the elderly with chronic diseases, the pharmacist-provided services focused on:

1. identification and resolution of drug-related problems
2. provision of compliance-enhancing packaging of medications for high-risk patients
3. administration of vaccines such as flu and pneumonia

A state study conducted in 1997 showed that payment for those pharmaceutical care services, which led to drug therapy changes, resulted in a savings of over $78,000 over a period of 18 months after the pharmacist fees were already deducted.

Washington State Pharmacists Lead the Nation

Since mid-1996, Washington has led the nation with innovative programs designed to benefit patients. These programs have been cooperatively designed and implemented by numerous professional, educational, and government organizations. These services become more accessible and augment the services already provided by other health care practitioners, and are done in cooperation with the patient's primary physician or health professional. Areas of healthcare services include:

Smoking Cessation: The Washington State Pharmacists Association, in cooperation with the WSU College of Pharmacy, SmithKline Beecham, Glaxo Wellcome, and McNeil Consumer Products, began training and certifying pharmacists to provide comprehensive smoking cessation services based on the Agency for Health Care Policy and Research (AHCPR) recommendations for helping patients quit smoking. Washington has trained **over 100 pharmacists** thus far in providing management of medications and behavioral management of patients. Pharmacists are trained to ask patients about quitting and to assist them in determining what steps to take for the best chance of success for that patient's personal situation. A one-year, pilot project has just been completed in our state with the Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA). Pharmacists at 18 pharmacies encouraged and educated Medicaid patients to quit smoking and to assist them in doing so. Preliminary results demonstrate the high degree of smoking cessation effectiveness of pharmacists and suggest long-term savings to Medicaid in reduced health care costs.

Immunizations: The Washington State Pharmacists Association, in cooperation with the Centers for Disease Control (CDC), developed a comprehensive program designed to train and certify pharmacists to provide these services based on the CDC's methods and recommendations for immunizations. Pharmacists recognized the urgent need to immunize more people by making these services more accessible and providing immunizations to those that might not be reached elsewhere. **Over 400 pharmacists** in our state are currently trained and certified to provide immunizations and are practicing in diverse settings from the community pharmacy to hospitals to community clinics in providing these services. ***Pharmacists have administered more immunizations in Washington State, than in all other states combined.***

Emergency Contraception: In order to lower the number of unintended pregnancies in Washington State, the Washington State Pharmacists Association, in cooperation with the Program for Appropriate Technology in Health (PATH), Wash. State Dept. of Health's Board of Pharmacy, and U.W. School of Pharmacy, developed a "first in the nation" program. Pharmacists prescribe emergency contraception pills, counsel patients on contraceptive methods and refer patients to other providers for follow-up care. Using prescriptive protocols in cooperation with physicians in their communities this allows patients unprecedented access to Washington pharmacists to receive treatment in what is often a very difficult and time-sensitive situation. **Over 1200 pharmacists** in more than 145 pharmacies in our state are currently trained and certified to provide emergency contraception services. Using the 1-800-NOT-2-LATE toll-free number, patients may locate pharmacists to help them. ***Over 50 percent*** *of women surveyed said they obtained these services on a weekend or after 6 p.m. on a weeknight, when locations and services other than the pharmacist would have been difficult to obtain.* **Over 20,000 emergency contraception patient visits with a pharmacist have occurred since the project began in 1998.**

Hyperlipidemia Study: The Washington State Pharmacists Association, in cooperation with Bristol-Myers Squibb and KOS Pharmaceutical, initiated a project providing equipment and lipid management certification training to over 100 pharmacists at over 50 pharmacies in our state. This efforts allows pharmacists to screen patients for high cholesterol levels, monitor physician-prescribed drug treatments and educate patients about the need for appropriate diet and physical activity, and to refer patients for appropriate follow-up. This study will provide information to demonstrate the role pharmacists can play in community health care and disease management.

These pharmacist-provided health care services have now become models for other states that are beginning to have similar success with providing patients with pharmacist health care services.

See the back of this page for a list of Washington pharmacy organizations.

Pharmacy Organizations in Washington

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