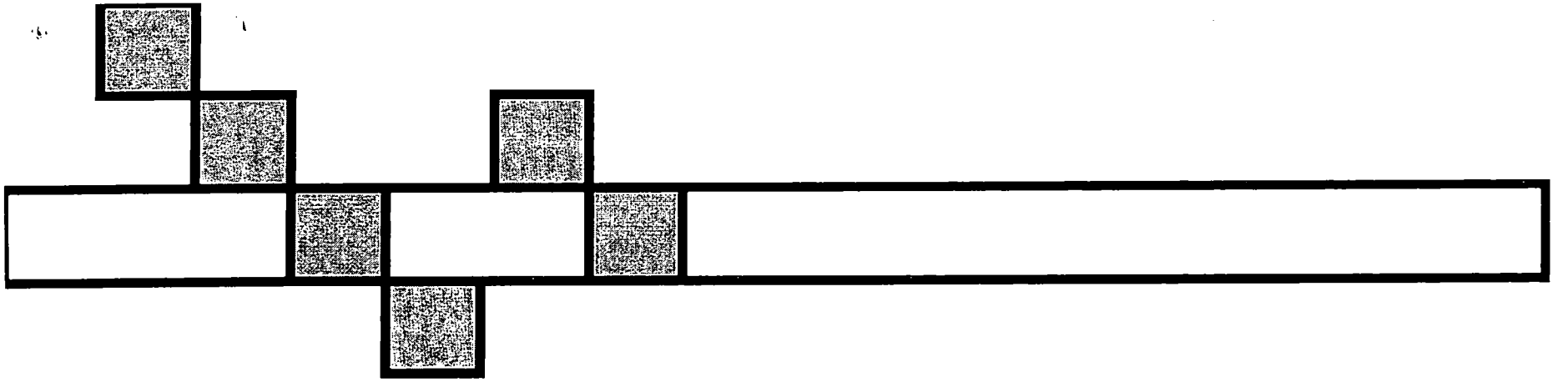

Collaboration in the Northwest

Dr. Joseph E. Pizzorno
President Emeritus, Bastyr University

Appendix 9

Welcome

- We are honored and excited you are visiting us these two days
- Many organizations in the northwest have worked together the past two months to prepare what we hope will be a highly informative experience for you

The organizations that provided the funding and personnel

- King County 2010
- King County Council
- Region X Public Health
- Bastyr University
- American Massage Therapists Association
- Washington State Chiropractic Association
- Washington Association of Naturopathic Physicians

Themes

- We worked hard with the invited speakers to organize their presentations in the context of the four categories mandated by Congress
- Through the information and recommendations provided, we hope you will hear 14 key themes, which I will present shortly

Successful Collaboration Requires Broad Commitment

- Local, state, and regional levels
  - Governmental bodies
  - Regulatory agencies
  - Academic institutions
  - Practitioners
  - Public Health officials and organizations
  - Payors

14 Themes

1. CAM is about systems of healing, not isolated therapies

- Natural (CAM) medicine is defined by philosophical system, not modalities, or the substitution of "green drugs" for synthetic drugs
- These "systems" change the way we think about and provide health care
- They even change the measures of success

2. This "integration movement" in the Northwest is not only about integrating CAM

- It is about mutual collaboration to create a true health care system, not the limited disease-treatment system that today dominates thinking and resource allocation
- Mainstream medicine must shift its mission/focus to health creation
- Are we talking about grafting CAM onto conventional or conventional onto CAM?

3. Facilitate collaboration

- Conventional practitioners
- CAM practitioners
- Public health
- Regulatory
- Payors
- Governmental

4. Research outcomes first, not isolated therapies

- CAM is Multifactorial
- Patient satisfaction and quality of life are critical measures
- Just as we have reaped tremendous benefit by a huge investment in conventional medicine research, similar benefits will be found by investment in CAM
- Develop consensus on research programs appropriate for CAM

4. Research outcomes first, not isolated therapies (cont'd)

- Fund research on payer databases to compare outcomes
- Fund cost effectiveness studies
- Host joint sessions for CAM and CM researchers and institutions to discuss and plan for collaborative research
- Reorient the focus of CAM research from 90% bench and clinical trials to 90% outcomes, field research, and training of CAM clinicians to perform in-office research

5. Level the playing field

- Disparities between CAM & CM (accredited & emerging) education, maturity and research is due to disparities in federal funding
- CAM schools need support for education
- Create and fund CAM-accredited Health Centers of Excellence

6. Strengthen accountability

- Accountability and standards critical for public protection
- Support activities that communicate and respect existing standards in emerging professions
- Fund initiatives to improve and further develop standards
- Accreditation
- Practice guidelines

6. Strengthen accountability (cont'd)

- Education
  - CAM practitioners
  - Conventional practitioners wanting to practice CAM systems or use CAM modalities
- National certification boards with credible testing and credentialing processes
  - Practices
  - Modalities

7. Critical need for appropriate nation-wide regulatory environment and standards

- Uniform licensure, regulation for public safety
- National board exams
- Collect and disseminate information about state regulatory models that are working well to provide access and protect the public.
- Encourage states to work together on the development of effective regulatory models

7. Critical need for appropriate nation-wide regulatory environment and standards (cont'd)

- Adapt federal guidelines to accommodate the natural life cycle of emerging professions
- Encourage self-regulation of education and practice in a credible way
- Develop national certification and/or credentialing standards based on the best available in each profession

7. Critical need for appropriate nation-wide regulatory environment and standards (cont'd)

- Encourage continuous improvement in those standards as educational institutions and examining boards improve
- Constitutionally, health care regulation and licensing is a state prerogative, but feds can help with suggested standards, and financial incentives

8. Help the CAM professions mature

- Practice guidelines
- Credentialing systems
- Peer review (interdisciplinary and CAM)
- Federal programs (Medicare, NHSC, etc.)
- Infrastructure at CAM institutions
- Fund research fellowships and training for CAM educators and providers
- Provide NIH consultation to CAM schools that want to engage in research

9. Deeply engage CAM professionals at all levels of evaluation and decision making

- CAM professionals have considerable and sophisticated expertise
- Health related committees and advisory bodies should require CAM educators and practitioners as expert advisers, consultants and/or researchers

10. True integration & collaboration require joint training programs and clinical experiences

- Practitioners who train together, practice together
- Not just CAM and Conventional but public health as well
- Support strategies for expanding integrated care settings in which conventional, CAM and public health providers practice side-by-side, learning from each other and being jointly committed to improved quality of care

11. Include special-needs populations

- Underserved (poor/uninsured)
- Reduce health disparities
- Special needs, e.g., HIV/AIDS, the elderly

12. Reimbursement system needs careful reconsideration

- Health-promotion vs. disease-treatment coverage
- Eliminate penalty for preventive services
- Be sure to include payer perspective

13. Critical need for accurate information for public and professionals

- Content databases: validate intervention efficacy & safety (Cochrane & others)
- Adverse events, reporting, monitoring
- Disseminate comprehensive information about education, scope of practice, and the impact of different regulatory models (and the lack of regulation) in the established and emerging CAM disciplines

13. Critical need for accurate information for public and professionals (cont'd)

- Provide education in, and a readily available database of, herb-drug-nutrient interactions
- Provide information on CAM practitioner education and standards of practice

14. Critical need for natural product quality assurance, either private or public

- Implement an effective program for ensuring product quality
- Products should contain what the label indicates, and ONLY that
- Appropriate standards for structure, function and health claims

Ultimately, good health comes from personal decisions

- This means public health critical for any real long term change
- I believe the reason public health has been so receptive to CAM is the commonality of our philosophies:
  - Education
  - Prevention
  - Healthful living
  - Self-help
  - Personal responsibility for health

At the End of These Two Days, I Think You Will:

- See the value of collaboration
- Recognize the importance of standards and accountability
- That this remarkable phenomenon in the NW is not only about integration or leveling the playing field, it is about a shared vision to create a true healthcare system, not the limited disease-treatment system of today

APPENDIX 10

Recreating Health Professional Practice for a New Century

The Fourth Report of the Pew Health Professions Commission

December 1998

Pew Health Professions Commission

Twenty-one Competencies for the Twenty-First Century (Chapter IV)

1. Embrace a personal ethic of social responsibility and service.
2. Exhibit ethical behavior in all professional activities.
3. Provide evidence-based, clinically competent care.
4. Incorporate the multiple determinants of health in clinical care.
5. Apply knowledge of the new sciences.
6. Demonstrate critical thinking, reflection, and problem-solving skills.
7. Understand the role of primary care.
8. Rigorously practice preventive health care.
9. Integrate population-based care and services into practice.
10. Improve access to health care for those with unmet health needs.
11. Practice relationship-centered care with individuals and families.
12. Provide culturally sensitive care to a diverse society.
13. Partner with communities in health care decisions.
14. Use communication and information technology effectively and appropriately.
15. Work in interdisciplinary teams.
16. Ensure care that balances individual, professional, system and societal needs.
17. Practice leadership.
18. Take responsibility for quality of care and health outcomes at all levels.
19. Contribute to continuous improvement of the health care system.
20. Advocate for public policy that promotes and protects the health of the public.
21. Continue to learn and help others learn.

Appendix II

Naturopathic Medicine: Integration Models

Professional Standards, Guidelines and Processes

Element	*Agency*	*Date established*	*Model for/Use*
Professional Accreditation	Council on Naturopathic Medical Education (CNME)	1978	Model for physician level training program and competency assessment in comprehensive natural family medicine (NM) and integrated medicine (IM)
Regional Accreditation	Northwest Association Of Schools and Colleges (NASC)	1983	Higher education standards for NM/IM physician training
Accredited Curricula	Naturopathic Medical Colleges, (CNME,NASC)	1978 - present	Detailed course, credit, and skill integration of sciences diagnosis, treatment, clinical theory, CAM modalities and clinical courses
State Licensure Model Law	11 State Governments** AANP Website www.naturopathic.org	1919 - present 1993	Scope of practice for NFM/IM physician matched to educational standards, and discipline
Guidelines of Naturopathic Medical Practice	American Association of Naturopathic Physicians	1995	Practice guidelines for NM/IM:based on Naturopathic principles
Professional Peer Review: Disciplinary Committees	11 State Licensing Boards and Naturopathic Advisory Committees	1919 - present	Safe and ethical practice standards and enforcement. Public recourse for grievances
Professional Peer Review: Case Management	American Complementary Care Network: Cdentialling And Quality Improvement Committee.	1998	Best practices expert panel, ensuring safety, efficacy and cost effectiveness: case management
Professional Peer Review: Quality Improvement Plan	State of Washington, Department of Health (approved) Washington Association of Naturopathic Physicians(administered)	1996	Continuous quality assurance, quality improvement plan
National Board Examination	NPLEX Naturopathic Physicians Licensing Examination	1982	Model for assessing graduates eligibility for licensure

Naturopathic Medicine: Integration Models

Naturopathic Clinical Theory and Principles of Practice	Lindlahr: Nature Cure Zeff: The Process of Healing(Journal of Nat Med. AANP: Definition of Naturopathic Medicine; Principles of Practice	1914 1993 1989	Clinical integration framework for applying CAM modalities effectively in primary whole patient care and health promotion
Continuing Education Standards	11 State licensing law	1919 - present	Keeping skills current

** Alaska, Arizona, Connecticut, Hawaii, Maine, Montana, New Hampshire, Oregon, Utah, Vermont, Washington and Puerto Rico

Appendix 12

Naturopathic Medicine
Professional Standards,Guidelines and Processes

Affiliated Organizations

Council on Naturopathic Medical Education
P O Box 11426
Eugene, OR 97440-3626
Executive Director: 541-687-7183
E-mail: dir@cnme.org
Web: www.cnme.org

Northwest Association of Schools and Colleges
1910 University Drive
Boise, Idaho 83725
208-334-3210

American Association of Naturopathic Physicians
Executive Director: Sheila Quinn
601 Valley St., Suite 105
Seattle, WA 98109
206-298-0126
E-mail: 74701.3063@compuserve.com
Web: www.naturopathic.org

Naturopathic Physicians Licensing Examination Board (NPLEX)
Executive Director: Christa Louise
P O Box 69657
Portland, Oregon 97201
503-250-9141
E-mail: 73422.3360@compuserve.com

Naturopathic State Licensing Boards
See list at the end of this reference

State Professional Associations

[For more detailed information, access the AANP website "www.naturopathic.org"]

Alaska Association of Naturopathic Physicians
907-563-6200

Arizona Naturopathic Medical Association
602-493-2273

California Association of Naturopathic Physicians
707-544-5546

Colorado Association of Naturopathic Physicians
303-331-6919

Connecticut Society of Naturopathic Physicians
860-295-1343

District of Columbia Association of Naturopathic Physicians
202-244-4545

Florida Naturopathic Physicians Association Inc.,
305-759-6689

Hawaii Society of Naturopathic Physicians
808-871-4722

Idaho Association of Naturopathic Physicians
208-743-1168

Nebraska Association of Naturopathic Physicians
402-391-6714

New Hampshire Association of Naturopathic Physicians
603-427-6800

New Jersey Association of Naturopathic Physicians
201-385-7106

New Mexico Association of Naturopathic Physicians
505-758-9704

New York Association of Naturopathic Physicians
516-929-7320

North Carolina Association of Naturopathic Physicians
919-490-4930

Oklahoma Association of Naturopathic Physicians
918-449-8343

Maine Association of Naturopathic Physicians
207-798-3993

Maryland Association of Naturopathic Physicians
410-356-4600

Massachusetts Society of Naturopathic Physicians
508-830-1644

Michigan Association of Naturopathic Physicians
313-944-6315

Minnesota Association of Naturopathic Physicians
612-227-1803

Montana Association of Naturopathic Physicians
406-459-5096

Oregon Association of Naturopathic Physicians
503-256-0931

Pennsylvania Association of Naturopathic Physicians
717-283-5194

Puerto Rico Association of Naturopathic Physicians
809-751-4682

South Dakota Association of Naturopathic Physicians
605-339-9080

Texas Association of Naturopathic Physicians
972-490-3703

Utah Society of Naturopathic Physicians
801-224-5780

Vermont Association of Naturopathic Physicians
802-985-8250

Washington Association of Naturopathic Physicians
206-547-2130

Naturopathic Colleges

Bastyr University
President: Joseph Pizzorno, Jr., N.D.,
14500 Juanita Drive N.E.,
Kenmore, WA 98011
425-823-1300
Web: www.bastyr.edu

National College of Naturopathic Medicine
President: Clyde B. Jensen, Ph.D.
049 S.W. Porter
Portland, OR 97201
503-499-4343
Web: www.ncnm.edu

Southwest College of Naturopathic Medicine and Health Sciences
Interim President: David C. Marchese
2140 East Broadway
Tempe, AZ 85282
602-858-9100

University of Bridgeport
College of Naturopathic Medicine
60 Lafayette St.,
Bridgeport, Connecticut 06601
203-576-4109

The Washington Association of Naturopathic Physicians (WANP): Coordinated Quality Improvement Program (approved Washington State Dept. of Health 1996) available from CQI Committee Chair: Jennifer Booker, N.D., Washington Association of Naturopathic Physicians (see state association list)

The Alliance for State Licensing of Naturopathic Physicians
Legislative Director: Scarlett Moss
601 Valley St., Suite 105
Seattle, WA 98109
206-298-0126
E-mail: director@allianceworkbook.com
Web:"allianceworkbook.com"

American Complementary Care Network
Credentialling, Risk Management and Quality Improvement Committee
CQI Committee Chair: Jennifer Booker, N.D.
Utilization Management Director: Rob Martinez, .D., D.C.
Medical Director: Bruce Milliman, N.D.
5620 Smetana Drive, Suite 225
Minnetonka, Minn. 55343
1-800-873-4575

Definition of Naturopathic Medicine:
Principles of Practice
American Association of Naturopathic Physicians
Select Committee on the Definition of Naturopathic Medicine, 1987-1989

Practice Guidelines Committee
Guidelines of Naturopathic Medical Practice
American Association of Naturopathic Physicians

State Licensing Boards

Federation of Naturopathic Medical Licensing Boards, Inc.
President: Nancy Dunne-Boggs, ND (406) 728-8544
715 Kensington Ste 24A
Missoula, MT 59801
Email: mrsboggs@montana.com
Vice President: Richard Barrett, ND (503) 239-6595
Email: rbarrett@teleport.com

Naturopathic Physicians Licensing Examination Board (NPLEX)
President: Ed Hofmann-Smith, ND (503) 252-8214
Email: 74771.2561@compuserve.com
Executive Director: Christa Louise (503) 250-9141
Email: 73422.3360@compuserve.com
P. O. Box 69657
Portland, OR 97201

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Alaska Department of Commerce and Economic Development
Division of Occupational Licensing
Naturopathic Section
Licensing Examiner: P.J. Gingras (907) 465-2695
Email: P.J._Gingras@commerce.state.ak.us
P. O. Box 110806
Juneau, AK 99811-0806

Arizona Naturopathic Board of Medical Examiners
Executive Director: John L Brewer, NMD ~~(602) 542-3095~~
Chair/Federation Rep: Robert Gear, NMD ~~(602) 263-8484~~
1400 W. Washington, Room 230 (602) 542-8242
Phoenix, AZ 85009

Board of Governors, Association of Naturopathic Physicians of British Columbia
President: Kelly Farnsworth (604) 925-3037
Vice President: Heather Naesgaard, ND (604) 980-4181
Federation Rep.: Carl Phillips, ND, DC (250) 334-8589
Email: anpbc@msn.com
Executive Director: Carolyn Chiasson
Phone (604) 688-8236 FAX (604)688-8476
Suite 218 409 Granville St
Vancouver, BC V6C 1T2

Connecticut Board of Naturopathic Examiners
Contact: Jackie Leduc (860) 509-7563
Federation Rep.: Robert Murphy, ND (203) 482-4730
Connecticut Department of Public Health
410 Capitol Ave., MS#12APP
PO Box 340308
Hartford, CT 06134-0308

Hawaii Board of Examiners in Naturopathy
Executive Officer: Michael D Machado (808) 586-2701
Federation Rep.: Jack Burke, ND (808) 593-9445
P. O. Box 3469
Honolulu, HI 96801

Board of Complimentary Health Care Providers (Maine)
Contact: Jerri Betts (207) 624-8625
35 State House Station
Augusta, ME 04333

Montana Alternative Health Care Board
President: Michael Bergkamp, ND (406) 442-2091
Program Manager: Cheryl Brandt (406) 444-5436
Department of Commerce, Professional and Occupational Licensing Division
111 N. Jackson St.
Helena, MT 59620

State of New Hampshire
Department of Health and Human Services
Naturopathic Board of Examiners
Christine Topham
6 Hazen Drive
Concord, NH 03301-6527
(603) 271-5127

Ontario Board of Directors of Drugless Therapy-Naturopathy
Federation Rep.: Jim Spring, ND (416) 236-4593
Office Administrator: Jane Lowe
4195 Dundas St. W., Ste 206
Etobicoke, Ontario, CANADA M8X 1Y4

Oregon Board of Naturopathic Examiners
Executive Director: Kathy Soderberg (503) 731-4045
Federation Rep.: Richard A Barrett, ND (503) 255-4860 x 139
Email: internet.orgovt:Kathy.SODERBERG@state.or.us
800 NE Oregon St. #21
Portland, OR 97232

Vermont Secretary of State
Professional Regulations
26 Terrace Redstone Bldg
Montpelier, VT 05602
(802) 828-2363

Washington State Naturopathic Physician Licensing Program
Robert J. Nicoloff, Executive Director
Washington State Naturopathic Advisory Committee
Ken Harmon, ND, Committee Chair
1300 Quince St.
PO Box 47860
Olympia, WA 98504-7860
(360) 664-9093

December 4, 2001

Dr. Joseph M. Kaczmarczyk
White House Commission on Complementary and Alternative Medicine Policy
6707 Democracy Blvd.
Room 880, MS-5467
Bethesda, MD 20982

Dear Dr. Kaczmarczyk,

On behalf of Naprapaths practicing in the United States, I wish to thank you for giving us the opportunity to submit comments to the White House Commission on Complementary and Alternative Medicine Policy.

1. **Are there national educational standards for Naprapathic undergraduate, postgraduate and continuing education?**
   Should those national educational standards include exposure to conventional medicine as well as CAM other than Naprapathy?
   Currently we are in the process of establishing national standards for Naprapathic education. We believe in national education standards for Naprapathy as well as for other CAM professions. We believe that national education standards should include exposure to conventional medicine. Naprapaths provide treatment for all related neuro-musculoskeletal disorders and have expertise with connective tissue disorders. Part of the standards of education of Naprapaths includes recognizing when to refer to conventional medical practioners when a patient may require their services. Naprapaths, believe that our profession is a complement to conventional medicine – and therefore Naprapaths are taught thorough history taking, assessment skills, determination of a referral to another licensed healthcare practitioner, treatment planning, and clinical biosciences. Naprapaths work with conventional medical personnel for laboratory and diagnostic tests. We believe that national education standards that expose CAM practioners to conventional medicine is beneficial and in the interest of the consumer/patient.

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

   We support the establishment of national standards for all CAM practioners. Naprapaths are board certified in Naprapathy and nutritional counseling. We are in the process of creating national standards for Naprapaths and currently use the standards and guidelines of the American Naprapathic Association, Council on Colleges.. These guidelines and boards on colleges and curricula set by the Naprapathic profession were instituted for practioners of Naprapathy to meet a certain criteria and standard of competence in order to protect the health, welfare

and well-being of the general public. We believe that those who are board certified are competent in their education and training to uphold a high standard of care. In addition to upholding a high standard of care, ANA members abide by a Code of Ethics.

The following outlines in details the standards of eligibility for licensure in Naprapathy in the states where Naprapathy is currently regulated by licensure. Currently there are 3 states that have laws regulating the practice of Naprapathy. The usual competencies required for persons entering this occupation as a Doctor of Naprapathy are:

a. At least 21 years of age
b. Graduated from a 2 year pre-professional college or its equivalent attaining 60 hours of pre-professional education
c. Graduated from a 4 academic year, 3 calendar year curriculum in Naprapathy approved by the American Naprapathic Association's Council on Colleges
d. Passage of the national boards given by the Naprapathic Boa rd of Naprapathic Examiners (NBNE)

. To receive a degree of Doctor of Naprapathy (D.N.), a student must complete 4 years of Naprapathic college education which includes 120 semester hours, 60 hours of advanced seminar hours and 1000 hours of clinical practice hours (20 hours/week for 50 weeks; giving a minimum of 350 treatments and 100 nutritional consultations).
The Naprapathic Council On Colleges (NCOC) sets the standards for education and examination requirements. After completing 120 semester hours, there is a 6 hour Comprehensive Written Exam and a separate one-hour Naprapathic skills exam that must be passed before the student may begin the hours of clinical practice. The NCOC supports rigorous training and education standards met by all who receive the degree of Doctor of Naprapathy.

The Naprapathic Board of Naprapathic Examiners (NBNE) gives the national boards, are divided into Part I Basic Sciences, Part IIA Naprapathic Science, Part IIB Naprapathic Practical. The Basic Sciences tests the knowledge Core of Basic Science curriculum of the applicant regarding Anatomy, Applied Biomechanics, Biochemistry, Connective Tissue Dynamics, Exercise Physiology, Biomedicine/Histology/Genetics/Embryology, Kinesiology, Laboratory Interpretation and Symptomology, Microbiology and Public Health, Neuroscience, Organic Chemistry, Pathology, and Science of Nutrition and Diet. The basic sciences provide exposure to conventional medicine.

Part IIA of the Board consists of Naprapathic Science, which tests the skill and knowledge of that the applicant develops in regards to analytical and manipulative skills: this part of the test includes accessory techniques, Adjunctive therapies, clinical preparation, ethics and jurisprudence, gross anatomical examination, clinical nutrition, clinical orthopedic and neurological evaluation, Naprapathic charting and clinic at evaluation, clinical protocols and evaluation, Naprapathic history and philosophy, Naprapathic technique, Naprapathic therapeutics, physiologic therapeutics, principles of

rehabilitation, principle of matter, spinal anatomy, sports and exercise injury assessment and treatment, therapeutic exercise and integrational clinic seminars.

Part II B is a practical hands on test, that test s the applicant's manipulative, diagnostic treatment protocol and clinical expertise.

We believe that the profession itself best determines the establishment and evaluation of criteria for safe and effective practice. This profession believes in the idea of self-regulation by all CAM professions with respect to the implementation of national certification programs. We also believe that the in terms of public welfare, there must be continuity.

3. **Should the Naprapathic organizations come together to form a "community?" If so, and by whom should that "community" be formed?**
   At this time there are only a few Naprapathic organizations – the majority of Naprapathic organizations in the United States are affiliated in some way with the American Naprapathic Association. We support the development of a "community" of all Naprapathic organizations that can collaborate in a productive manner, yet still maintain respect for each organization's mission.

4. **Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply and how should they be implemented?**
   We strongly believe there should be condition specific and modality specific practice guidelines in CAM and believe that the profession itself should develop these guidelines. We believe regulation and licensure will help correct or preclude consumer injury by setting minimal education standards, mandating continuing education, and defining scope of practice guidelines for each CAM profession. In doing this, the consumer is protected from potentially unskilled practitioners and clever marketers with questionable credentials.

5. **Are your members concerned about malpractice liability associated with providing CAM practices and products?**
   Like any other healthcare professional, Naprapaths are concerned about malpractice liability issues. Currently, Naprapaths like other licensed CAM specialties enjoy an excellent safety record.

6. **Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?**
   Naprapaths, like other health care practioners are concerned with the standard risks that are inherent in health care – including treatment by unqualified individuals, misdiagnosis, and improper use of modalities. Naprapaths are concerned with maintaining a high standard of care. We believe in rigorous clinical training and well as relevant continuing education. For example,

Naprapaths are trained in biochemistry, physiology, nutrition and clinical nutrition. Naprapathic students are required to perform 100 nutritional counseling sessions in a clinical setting before graduation. Part of the continuing education for Naprapaths includes seminars in pharmacology, botanical medicine and clinical applications.

In regards to supplementation of botanicals, herbs, and enzymatics, we believe that these products should only be available through practioners trained in nutritional counseling. We believe that through proper education and certification or licensure with continuing education requirements will protect the public from drug interactions and illness due to contraindications.

7. **Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?**
We believe that there should be a mechanism to address consumer concerns or grievances about the professional competence and conduction in CAM practices. We believe these concerns should be first addressed by self- regulation and the adherence to the Code of Ethics, and second at the state level by licensing boards. The ANA membership adopted a Code of Ethics that clearly defines standards of conduct and professionalism. The Code of Ethics also has a definite procedure for disciplinary action.

   In regards to CAM products, we have no knowledge of any channels that address consumer concerns or complains. Because we also believe in "to first do no harm"- we would be interested in participating in recommending a program to address these concerns.

8. **What information should a conventional health care provider communicate to a CAM practitioners? What information should a CAM practioners communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?**
We believe the relationship between conventional health care providers and CAM practioners should be professional and respectful, with the interest in the patient as primary. We believe there should be appropriate communications with regards to patient history; evaluation/diagnosis and relevant information in regard to the patient's condition should be shared between practioners in order to provide the best standard of care for the patient.

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

We make the following recommendations to assure the quality of CAM practices and products for the benefit of the patient/consumer:

1. Practioners must graduate from a formal, full-time school or college in their specialty.
2. All practioners should be certified or licensed to practice their specialty
3. Expanding the student loan repayment plan to include CAM students.
4. Inclusion of Naprapathy and other CAM specialties in federal health insurance programs.
5. Federal funding for the development of public awareness campaigns about CAM.
6. Funding (federal and private) towards the improvement of research pertaining to CAM.
7. Development of continuing education guidelines to keep updated on latest developments and research in CAM fields.

Thank you for taking the time to consider the information presented in this letter. Please feel free to utilize the ANA as a resource for current information about the standards of competency and practice within the field of Naprapathy. If you have any questions, please feel free to contact me by email at naprapathic1@hotmail.com or by telephone at (773) 847-9316.

Warmest regards,

Sharon DeVita, M.A., D.N.
Vice-President

AMERICAN BOARD OF HOLISTIC MEDICINE, INC

Administrative office
Box 5388
Lynnwood, WA 98043
Tel (425) 741-2996
Fax (425) 787-8040
e-mail blh@halcyon.com

Professional office
614 Daniels Drive NE
E. Wenatchee, WA 98802-4036
Tel/fax (509) 886-3708
e-mail nhf@satnetcomputers.com

August 1, 2001

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on Complementary
and Alternative Medicine Policy
6707 Democracy Boulevard
Room 880, MS - 5467
Bethesda, Maryland 20892

Dear Dr. Groft:

Pursuant to requests for further input at the Seattle meeting of the Commission in February 2001, and pursuant to questions asked in correspondence with Dr. Kathi Fry, past president of the American Holistic Medical Association, I am responding with the following comments.

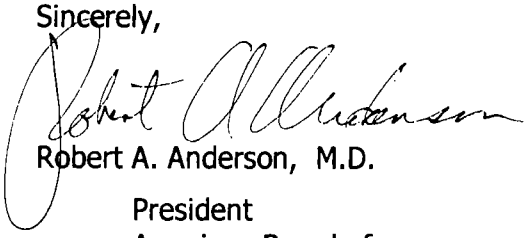
1. In the view of the American Board of Holistic Medicine, there is a sufficiently large database with information in thirteen arenas for Holistic Medicine to be legitimately recognized as a specialty in its own right. Holistic medicine may be defined as the art, science and practice of medicine which utilizes the best of alternative and conventional medical approaches, emphasizing the promotional of optimal health including the physical, emotional, mental, spiritual social and environmental aspects of human experience. Thus, it encompasses and integrates alternative medicine and conventional medicine in a complementary fashion.
2. The issue of standard setting is paramount. The ABHM has begun the process by the offering of a comprehensive qualifying examination for professionals with allopathic and osteopathic degrees to be certified as holistic physicians. The ABHM is at this point independently constituted, and emphasizes a knowledge base which includes Exercise Medicine, Nutritional Medicine, Environmental Medicine, Biomolecular Medicine, Behavioral Medicine, Spiritual Medicine, Energy Medicine, Social Medicine, Manual Medicine, Homeopathic Medicine, Botanical Medicine, Ethnomedicine including acupuncture, and Conventional Medicine. Most holistic physicians are not themselves fully trained in more than two or three alternative techniques, but need to have a minimal level of competence with all areas to be able to effectively work with those non-M.D.-D.O. practitioners who are fully trained. The first comprehensive qualifying examination in Denver in December of 2000 reflected these views.

3. The question of gatekeepers is an unresolved one at this point. The model of practice which we as holistic practitioners view as the optimal model of the future includes a community clinic staffed with two or three holistic primary care physicians, one or two counselors, a naturopath, with a variety of other practitioners utilized either full or part-time, such as an osteopath or chiropractor, massage therapist, acupuncturist, pastoral counselor, health and nutrition educator, etc. Appropriate intramural referrals would flow from this arrangement, with extra-mural referral to both additional alternative practitioners and allopathic specialists and sub-specialists including hospitalists. Training in the gatekeeper would assure much greater likelihood of success of these multidisciplinary facilities. Classes and groups, led by a variety of practitioners would be a major emphasis of such a clinic, stretching and enhancing the opportunities for patient-practitioner contact.
4. A greater sense of collegiality and cooperation between academic sites developing complementary-alternative programs and practitioners who have been in the alternative-integrative-holistic field for one to three decades would enhance faculty development, and utilize the experience of those who have been pioneering these efforts. The first ABHM board-certifying examination attracted approximately twenty practitioners with relationships to academic institutions, and we anticipate this relationship will grow fairly rapidly in the next three to five years.
5. Private foundations and the Office of Alternative Medicine may be resources for funding. The interest in such training is, by our estimate, extremely high, particularly among the student and practicing physician population. Properly practice facilities should be self-supporting within a year or two of founding, and properly constituted training programs should be able to operate on the same funding basis as most academic conventional programs. I cannot overemphasize the high student interest. The American Holistic Medical Association fields hundreds of requests each year from students wanting a "Holistic Residency."
6. Continuing education requirements for integrative-complementary-holistic practitioners are essential. While the ABHM has elected not to require periodic re-certification, as such, a modified recertification process will be instituted including, among other requirements, submission of continuing education study hours, part of which will be required from alternative as well as conventional areas.
7. National continuing education standards would be desirable. Could they be certified through the Department of Education? The beginning of the setting of perr-reviewed standards, as I indicated above, has been initiated by the ABHM.
8. An unmet need for alternative education for M.D. practitioners has been the difficulty in finding ACCME-affiliated co-sponsors for category-1 programs. The AHMA, admitted to provisional status affiliated with the ACCME in 1979, was denied permanent status in 1981. Some institutions offering co-sponsorship of programs with the AHMA in the past have been threatened with termination of their ACCME affiliation if they repeated such co-sponsorship. Some state licensure boards do not accept CAM practice education hours. The AAFP will not accept CAM programs for prescribed credit unless the training is to learn about CAM and not how to practice the modalities.
9. Credentialling would ideally be done at a national level. The Office of Alternative Medicine could possibly become involved with this. Input for minimal level knowledge from the various alternative professions should be sought.

10. I personally believe that the day may come when a malpractice suit is filed for failure to use an effective alternative modality. For instance, failure to recognize the need for magnesium supplementation in patients taking diuretics – emphasized in holistic nutritional medicine – often leads to fatal arrhythmias and could easily be the subject of a malpractice suit.
11. The ABHM directors believe that the institution of our certification examination and the intensive training course associated with preparation for the exam, together with the published elements of the curriculum are major steps forward in the establishment of quality and accountability. The issue of regulation and standardization of supplements remains an open question at this time. Whether the industry will be able to establish standardization and certification of reproducible content of active ingredients in botanical products is still uncertain at this time.
12. The ABHM has interest also in the establishment of a Holistic Family Practice Residency. A number of possibilities are under current discussion. With the advent of a Holistic Residency, all requirements for the application of the ABHM to the American Board of Medical Specialties would be feasible. The ABHM is also vitally interested in fostering the advent of a multi-disciplinary community clinic practice model which I described above.

We remain avidly interested in the work and findings of the Commission. Please keep us on a mailing list, and if we can be a resource for the commission in any way, we would be happy to do so.

Sincerely,



Robert A. Anderson, M.D.

President
American Board of
Holistic Medicine

COPY

Dr. Kathleen Frye
President
American Holistic Medical Association
6728 McLean Village Drive
McLean, VA 22101-8729

Dear Dr. Frye:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at www.whccamp.hhs.gov.

The Commission will meet on February 22-23 to discuss the topic areas: education and training of health care practitioners, quality of care, and accountability, as they relate to complementary and alternative medicine (CAM). The questions that follow were developed to guide the Commission's deliberations. To accomplish its goal, however, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments by e-mail or fax by February 13th so that the Commissioners have enough time to review them before the February 22-23 meeting.

Questions Developed for Commission Discussion :

1. Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combing conventional western medicine with "alternative" therapies.)

2. What should be done to assure that integrative health providers have the appropriate education (knowledge) and training (skills) for their specific scope of practice? Should core competencies be established? If so, how would these "competencies" reflect the various levels of CAM integration – for example, practitioners who use their knowledge to make referrals to CAM providers, practitioners who have this knowledge but also incorporate one or more modified CAM techniques into their patient care, and practitioners who have extensive CAM knowledge and who furnish one or more CAM skills (such as acupuncture) as part of their practice.

3. What knowledge and core competencies – and credentialing -- should be required for an integrative health care provider to serve in the role of primary care practitioner (PCP)? Should chiropractors, acupuncturists, and other CAM providers be able to serve as PCPs? Should western trained providers have training in CAM to serve as gatekeepers and make referrals to CAM providers?

4. Who and what are needed in developing faculty for integrative health training programs? What are the issues in developing faculty, curricula, resources, etc.?

5. What recommendations or other guidance can be offered regarding funding for integrative health training programs?

6. Should there be continuing education (CE) requirements for all integrative health providers? Should integrative health professionals be required to demonstrate periodically that they maintain core competencies in the modalities they practice?

7. Should there be national CE standards for integrative health care providers? State standards? Professional standards? If so, who should be responsible?

8. What issues, unmet needs and problems currently exist for continuing education? (For example, do certain entities such as state licensure boards accept CAM CEUs?)

9. Should professional credentialing be performed by one, central body or at the state level? If so, who should be responsible? To what degree should the specific profession(s) be involved?

10. Are there medical malpractice issues that you would like to share with the Commission? For example, is there risk to practitioners who do/do not use CAM practices or products?

11. What other measures should be developed to promote quality and accountability amongst conventionally trained providers practicing CAM? Practice guidelines or modality-specific guidelines? Consumer protection programs? What about oversight or regulation of supplements?

Thank you for your invaluable help. Please send your written comments to Maureen Miller, MPH,RN, *fax: (301-480-1691), phone: (202-486-4337/cell or 301-435-6198),* and contact her with any questions you may have. She will be happy to work with you in any way she can to gain your expert advice

Sincerely,

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Barrie R. Cassileth, PhD
Chief, Integrative Medicine Service

Responses to Questions from the White House Commission on Complementary and Alternative Medicine Policy

Summary of Treatment Program

We provide a broad range of complementary therapies to both inpatients and outpatients at Memorial Sloan-Kettering Cancer Center (MSKCC). We distinguish between alternative and complementary therapies, a crucial distinction, especially in cancer medicine. "Alternative" cancer therapies often are promoted as literal alternatives to mainstream care. Alternative therapies by definition are unproved. They may delay or prevent needed care in a timely fashion. Numerous bogus products and programs are promoted as cancer "cures." We do not offer such "alternative" therapies.

Therapies used in the MSKCC Integrative Medicine Service are rational and backed by data indicating their value and utility. Our therapies include many mind-body interventions such as relaxation therapies, hypnosis and self hypnosis, meditation, and so on. Several different kinds of massage therapies are available, including foot massage or very light touch massage for patients who are frail or who recently completed surgery. Therapies most commonly requested by inpatients are massage and music therapy.

Our outpatient facility is located approximately two city blocks from the main MSKCC campus. In this spa-like environment free of biomedical paraphernalia, we provide a full array of services such as various types of massage, mind-body interventions, acupuncture, music and art therapy, and several classes. Classes include T'ai Chi, Yoga, special exercise regimens such as Chair Aerobics and Pilates, and other programs developed specifically for patients with cancer and their families. Nutritional and herbal counseling is also available to both inpatients and outpatients.

Our interventions are geared to enhance body, mind and spirit, and we remain open to developing new programs and providing additional therapies on the basis of patients' and family members' suggestions. Patients and others may self-refer, or they may be referred by their oncologists or other health professionals. Outpatient services are available to any cancer patient and family member, regardless of hospital affiliation.

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E-mail: cassileth@mskcc.org

Services to inpatients are delivered at no fee; outpatient therapies are appointment- and fee-schedule based. Our service program exists in the context of major research and educational activities, consistent with other MSKCC Services.

How program compares with conventional treatment of same or similar health conditions

Our complementary therapies do not compare with conventional treatment, because they are given as adjuncts or additions to conventional treatment for cancer. There are no viable "alternatives" to mainstream cancer care. Consequently, we are speaking of augmenting rather than replacing mainstream cancer care; we represent the quality of life arm of mainstream cancer treatment.

We have little doubt that our approach (combining mainstream and complementary therapies) is substantively superior to conventional care alone. Of course the most urgent and important aspect of cancer medicine is to destroy the tumor and bring about cure or prolong remission. At the same time, patients experience distressing symptoms that require intervention. Our emphasis is on managing pain, nausea and other symptoms during and after cancer treatment.

The program at Memorial Sloan-Kettering Cancer Center is new. Our clinical services have been available for one year. We provided over 6,000 client visits (3,439 outpatient visits and 3,049 inpatient visits) during our first eleven months.

We routinely collect data on each patient intervention to determine the extent to which the problem for which the patient required complementary services was ameliorated. The reduction in symptoms immediately after therapy for 1,412 MSKCC inpatients and outpatients was approximately 50% for all symptoms and across all therapies. In decreasing order of incidence, patients requested help for fatigue, anxiety, pain, depression, and nausea. Therapies included in these summaries are regular and light-touch massage, foot massage, music therapy, meditation, and mind-body/relaxation approaches. Only modest reduction in these symptoms after acupuncture reflected the view of many acupuncturists that a decrease in symptoms is rarely seen immediately following treatment.

Barriers to access and delivery of complementary therapies and policy recommendations to eliminate them

Several major barriers limit patient access to complementary therapies. A central issue concerns the need for additional data that fully document the efficacy of complementary modalities, including the clinical circumstances under which particular modalities are most effectively applied. Another problem arises from the conduct of poor quality research resulting in unreliable data. This is a serious problem because it generates

skepticism among healthcare professionals who then withdraw their support and decline to refer patients. This may be followed by lack of institutional support and absence of funding for program development. Limited insurance coverage for complementary therapies increases the financial burden on patients.

In order to eliminate some of these barriers it is essential for government policy to regulate, support, guide, and encourage high quality research in the field of CAM. Lastly, complementary therapies should not be viewed as competition to mainstream cancer medicine; rather the two should be integrated as is the case in the MSKCC program. In order to foster integration of the two fields it is imperative for future healthcare policy to validate the benefits of complementary therapies, disseminate results, and then provide appropriate coverage.

To whom should program be accessible? Stand alone or integrated with conventional care?

Complementary therapies in the cancer care setting represent an extension of supportive care, which has a long tradition in cancer medicine. In my view, all cancer patients and family members should have access to complementary therapies that address their quality of life needs while they are going through treatments and thereafter. Cancer medicine represents a unique component of health care in that we are not facing a decision of whether to use mainstream treatments or to use some unproven alternative. Rather, we strive to ensure patients' comfort, to relieve stress, and to decrease or eliminate symptoms.

There is a second reason for integrating complementary and mainstream cancer care: cancer represents a massive biological event, and its treatments are often extremely difficult. Approximately 55% of patients with cancer will be cured. This means, however, that many patients will experience progressive disease and will require special assistance as terminal stages of illness approach. In all stages of disease, it is absolutely essential that complementary therapists work along with oncologists to insure that particular therapies as well as their administration are consistent with patients' physiologic status.

Cancer care requires not only the emphasis on decreased symptoms and enhanced quality of life enabled by complementary therapies, but also insuring that these often fragile and very ill patients receive only care that will benefit them. In complementary as in mainstream medicine, the guiding principle is always "first, do no harm".

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To enable complementary and alternative medicine (CAM) to become more accessible and transparent, we need to win the complete trust of the conventional medical community, which is still suspicious if not hostile in many instances and on many occasions. It needs to be made clear that although CAM practices may be unconventional and its mode of action [eg in case of acupuncture] may not even be fully accountable by current biological sciences, but we need to ultimately judge CAM by outcome data. Quality clinical data is extremely costly to generate. Unfortunately, the trickle of public and private funding available for formal trials will make such data unavailable for many CAM modalities and interventions for a long time to come. This has to do with commercial issues such as patentability as well as profitability besides policy matters, and as such will need to be solved on a macro level over a period of time. Another important avenue to instill trust in CAM in the conventional medical community is to bolster CAM training for our young doctors and ancillary health providers. Although limited CAM curricula has been introduced into most medical schools, serious and in-depth CAM teaching, training and practice is sorely lacking at the internship/residency/fellowship levels, thus leaving most MD CAM practitioners largely self-taught or even self-professed. The overall quality of post-graduate CAM education can be enhanced with appropriate rotations in CAM during postgraduate training. Integrated offers of CAM related workshops and symposia during major annual medical conferences sponsored by the major medical societies and institutions. Education is much less expensive than research and over time may yield a higher return. It is imperative that a new generation of physicians and other health care providers develop crucial new awareness about CAM necessary for them to learn, accept, and practice it for the health and well-being of their patients.

Raymond Chang MD FACP