14 Mar 01

Steve,

Here's ~~the~~ agenda for Friday

FYI...

Joe

Comm[illegible] call [illegible] [illegible] & see what though they want in

June 11, 2001

Dear Dr. Kaczmarczyck,

It was great to talk with you last Friday. Here are my written recommendations for the interim report, as promised. I have focused on areas that I believe are critical and cross many communities. These are key themes for the report. The associated recommendations are priorities.

Commit to health care pluralism.
Maintain the gene pool of ideas by establishing and fostering diversity. Support separate but equal systems of healing. Support collaboration between these systems and development of new integrative systems. Health care diversity will enhance creativity, critical thinking, competition of ideas, and appropriate economic and market competition. Complementary and Alternative Medicine (CAM) integration policy should focus on the goals of Healthy People 2010, include an emphasis on public and community health and on service to the underserved. Health disparities and partnerships for health improvement are key areas where CAM services are quite effective.

- *Establish the Federal Office of Complementary and Alternative Medicine and Integrative Health Care* (OCAM-IHC). Establish an Office on CAM and Integrative Health Care at the U.S. Department of Health and Human Services with the authority to oversee, coordinate and direct all federal CAM activities through the Office; and direct and oversee incorporation of CAM in all federal benefits programs. Develop open, structured and ongoing communication pathways among legislators, regulators, public health, the research community Conventional Medicine (CM), CAM and IHC providers, researchers, educators and organizational representatives. Establish an Office of CAM and IHC in each DHHS, USPHS Region. Begin with offices in Region X and other regions with most extensive CAM and IHC activity.

- *Establish a Bureau of Emerging Professions within the OCAM-IHC* to assist emerging health care professions. This Office would provide guidance, funding opportunities, support, and accreditation guidelines to assist professions and communities of practice in improving their practice and accountability to the public without losing important and necessary innovations for health care. This process could be a means to actually accredit a profession and track its status clearly as it emerges and develops. This Bureau could be established through DHHS. Resources would be better spent for the public good if emerging professions could engage in a fostered process of developing and refining and accrediting their professions and practices with the goal of safe and effective public access, and innovations to improve community and individual health.

- *Facilitate diverse collaboration.* Mandate the inclusion of licensed CAM providers (LCPs)[1] for government advisory and staff positions in federal health care agencies and processes. Require key agencies to establish representation from all LCP groups on advisory boards. Examples include HCFA (Medicare, HCPAC) CDC, HRSA, HHS, IOM, AHCQR, BPHC and BHP. LCPs must be appointed to the Joint CPT Committee to address coding, evaluation, and management of CAM services. Ensure that LCPs and credentialed IHC proponents are represented on all federal CAM and IHC research Scientific Review Panels in addition to those at NCCAM.

- *Pass legislation to mandate inclusion of all licensed CAM providers and services*, accredited CAM colleges and students in all relevant federal programs. Patients must have equal access to all licensed and accredited provider types within their scopes of practice. Providers, schools and students must have equal opportunity to participate in federal programs funded by taxpayers who increasingly seek high quality CAM services and training. Include CAM accredited colleges in the Higher Education Act.

Support CAM students at professionally accredited CAM institutions.

CAM students are at a distinct disadvantage in CAM accredited institutions due to disparities in federal funding. All federal funding allocated for training licensed health care professionals is provided only to CM students (and CM allied health care students), except for limited access to student loans for CAM students. CAM students in training to become licensed health care professionals deserve the same public support afforded to conventional medical and allied health care students. To support CAM students, promote equal access to federal funding, jobs and reimbursement for them and for LCP graduates. It is essential to authorize federal funding for CAM students before or simultaneously with recommending CAM funding or authorizing legislation for CM students and medical doctors who wish to study CAM.

- *Federal Benefits Programs:* Research legislation and rules which control federal health care agencies. (B) Follow the example of NIHCCAM. Propose legislation, amendments and rule changes necessary to mandate inclusion of LCPs and IHC. This should be done in the WHC July report for any legislative recommendations or Executive Orders. Propose appropriations for LCPs and IHC in all appropriate federal programs. Approve accredited CAM colleges and LCP students for grant eligibility and eligibility for federal funding in all federal programs providing eligibility and funding to CM colleges and students. Add accredited CAM schools and their professional accrediting agencies to the enumerated lists of agencies under the Health Professions Act. Include LCPs in the Health Professions Education Partnership Act of 1998.

- *Residencies:* Provide funding for postgraduate residencies for licensed naturopathic physicians. Provide support for chiropractors, acupuncturists and direct entry midwives residency needs. Federal GME systems must authorize inclusion of LCPs and appropriations for residencies to establish an adequate number of residency sites for LCPs. Until equal federal funding is available for CAM graduate medical education it is not appropriate to require residencies. (C)

- *Student Loans:* Increase student loan limits to naturopathic medical students. The Secretary of Education has the authority to increase loan limits for unsubsidized loans with respect to students engaged in specialized training requiring exceptionally high costs of education. (Section 428H(d)(2) of the Higher Education Act of 1965). The Secretary has exercised this authority to grant higher loan limits to those types of medical or professional schools that had been part of the original Health Education Assistance Loan

[1] Licensed CAM Professions (LCPs): The distinctly licensed CAM professions: Licensed Acupuncturists (LAc), Naturopathic Physicians (ND), Chiropractors (DC), Direct-Entry Midwives (LM), Licensed Massage Therapists (LMT), Whole Foods Nutritionists and Dieticians (RD).

program (HEAL). In the interest in fairness, we recommend that the Secretary be directed to add the Colleges of Naturopathic Medicine accredited by the CNME to the list of institutions eligible for the higher limits from the Federal Family Education Loan (FEEL) and the William D. Ford Direct Loan Program.

- *Loan Forgiveness & Service to Rural and the Underserved*: Incorporate authorizing language including LCPs in the National Health Services Corp (NHSC) by amending the Primary Health Services Provision in the Reauthorization Bill. Propose appropriations to support inclusion of LCPs in the NHSC. Primary care LCPs are carrying student loans of up to $100,000. LCPs express strong interest in working in these communities due to the philosophies of their disciplines and their interests in public and community health. Shortages in CM primary care services are increasing. Rural communities are considering importing foreign graduates of CM schools to provide these services. Naturopathic physicians and chiropractors in some states can provide these services. Licensed acupuncturists, direct entry midwives and nutritionists can make obvious contributions to community health in shortage areas.

Support and fund CAM accredited school and universities.

Institutions and schools training LCPs must be supported in order to support a well trained and licensed CAM workforce. Quality health care education is essential to safe and effective health care services. Throughout the United States, CAM accredited schools are exceptional models and systems for this training. Unfortunately this training is supported almost entirely by student tuition. This is an unacceptable and unfair burden for students in these schools when the public is demanding access to high quality CAM services, and the federal government is providing funding to conventional medical schools for minimal CAM training. Students engaged in full training in CAM universities and schools must have equal access to the public resources that support conventional medical schools.

- *Authorize immediate inclusion of LCPs and CAM accredited institutions in the Public Health Services Act.* Both Title VII and Title VIII are up for re-authorization late this year. Health professions under MODVOP should be expanded to include LCPs. Title VII, which funds medical schools should be amended to include chiropractors and naturopathic physicians and their academic institutions. Title VIII provides funding for non-physician health care programs and should be amended to include licensed acupuncturists, nutritionists, direct entry midwives and licensed massage therapists. Amend and expand the Definitions Section (292A) to include the LCPs: NDs, DCs, LAcs, LMTs, LMs and Nutritionists. Recommending appropriations for CAM schools should be a priority, particularly if recommending increased appropriations to CM schools for CAM or IHC training.

- *Establish CAM accredited Academic Health Centers of Excellence* through the Public Health Services Act. Encourage these Centers to collaborate with IHC and CM Colleges. Recommend appropriations to support these Centers of Excellence as national resources.

- *Provide equal and immediate access to all other federal programs* providing public funding for medical doctors and nurses. If necessary, pass anti-discrimination legislation for all LCPs for broad inclusion of all federal benefits programs.

- *Direct the Health Resources and Services Administration* to provide federal UME-21 program grants to CAM accredited schools for curricular innovations in these schools.

Support equal access to licensed CAM providers and services.
Patients must have equal access to all licensed and accredited provider types within their scope of practice. Providers must have equal opportunity to participate in federal programs funded by taxpayers who seek high quality CAM services in growing numbers.

- *Allow access to licensed CAM professionals through federal health care programs.* Include licensed CAM professionals in Public Health Services and Community Health Centers administrative and clinical staff. Authorize LCPs as eligible to apply for federally funded health care positions.

- *The Health Care Financing Administration (HCFA) must incorporate legislative language* and promulgate rules to cover services for LCPs in all licensed states. The Medicare Act must be amended to provide for these changes. This authorizing language is central for LCPs' access to many federal and state programs. Provide Medicare and federal Medicaid state matching for services provided by LCPs within their scope of practice and Medicare/Medicaid's scope of covered services.

- *The Balanced Budget Refinement Act of 2000 (HR 3077) would improve services for Medicare recipients.* This bill allows GME payments for psychologists. Incorporate GME payments for licensed naturopathic physicians and other LCPs in this legislation or similar legislation. Authorizing language for ND and LCP residency funding in all GME funding streams should be written into this legislation (and rules) including authorizing Medicare direct and indirect GME, Children's Hospital GME, and Title VII grants from HRSA.

- *Authorize reimbursement through Medicare, Medicaid, government programs and private payers* for wellness and prevention services. Two examples are the Medicare Medical Wellness Act and the Medicare Medical Nutrition Act providing the sole right to have nutrition services reimbursed to registered dieticians. While registered dietitians should receive this coverage for services, this legislation must be expanded to include all CAM regulated professions whose training scope of practice provides regulated nutrition services. Provide tax incentives to individuals for wellness, prevention and self care. Reimburse for behavior change.

- *Fund integrated services in regional and local Community Health Centers.* HHS has increased the national budget for Community Health Centers significantly. An example is the provision of nearly $9.2 million in grants to 20 local health centers to expand access to health care for medically underserved communities. These grants are provided through the New Start/Expansion Program administered by HRSA. New health care sites will be created in 17 states. The initial round of grants was announced March 27, 2001; the third round will be announced in August with approximately 40 new grants. Authorize replication of the successful Community Health Centers of King County Integrated Clinic model through these grants. In addition, propose that HRSA appropriate funds to replicate this model through its Consolidated Health Centers (CHC) program. The President's proposed budget includes a $124 million increase in CHC funding. This is an especially timely recommendation as the number of conventionally trained primary care providers is decreasing.

Encourage and fund collaboration between CAM and CM institutions

Conventional, traditional, indigenous, complementary and alternative models of care, and their bodies of knowledge, have contributions to make health care which is culturally most appropriate and effective for individuals and communities. Best practices are discovered through exploring diverse structures for integration, including parallel, collaborative and assimilative models. Mandating and investing in true partnerships between accredited CAM and CM academic institutions is in the national public interest.

- *Provide financial incentives for equal CAM/CM institution partnerships.* Establish bonus funding incentives in grant applications between CM and CAM institutions who submit collaborative grants which model institutional partners as equals. Grants can be submitted for partnerships in research, academics, clinical services, and public affairs. For example, when a CAM school develops training opportunities for CM students, CAM students would be provided with equal access to training opportunities in the partnering CM school. Funding and governance structures in such grant applications should be fairly evenly balanced between institutional partners.

- *Exchange programs should be developed and encouraged between conventional and LCP accredited schools.* Providers who train together, work together. Authorize funding by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA). To develop programs with AAMC and AANMC, and LCP college consortia. Link licensed CM programs with licensed CAM programs to support dual training.

Support licensure consistent with educational standards.

Licensed and licensable CAM health care professions must have the choice to enter mainstream health care systems through the model of "credentiallability". It is appropriate for the federal government to set national goals. It is important for the federal government to take leadership and encourage credentialling and licensing in all fifty states for licensable CAM providers. The federal government must enact policies that will encourage CAM licensure and integration of CAM accredited standards of training. Federal support for licensure is important for both effectiveness and public safety. These policies can be enacted by authorizing coverage for federal services access to federal benefits programs and job eligibility based on appropriate training and licensure.

If a recommendation is not made in this report to support licensure of the CAM professions in remaining states and to support licensure in federal policy, this issue should be considered in a special session of the White House Commission before its final report in March 2002. This issue is critically important to the public.

- *Fund "National Credentialling and Standards Roundtable".* Include national conferences, with a Blue Ribbon task force representing accredited colleges of conventional healthcare and the licensed CAM and IHC professions, national associations for licensed CAM, CM, IHC, and emerging professions. Include organizations and task forces involved with standard setting in CAM and CM education from within conventional medical education. Produce white paper recommendations on training standards for CAM and IHC practice and education through consensus. This roundtable should be the first priority established for the Federal Office on CAM and IHC.

I would like to thank you, Steve and Michelle for your dedication and hard work to get this first draft ready for us to review. Please let me know if you have any questions.

Sincerely,

Joseph E. Pizzorno, ND

Commissioner; White House Commission on the
Integration of Complementary and Alternative Medicine Policy
President Emeritus
Senior Advisor to the President
Bastyr University

A -Federal OCAM-IHC

Establish a National Federal Office on Complementary and Alternative Medicine(CAM) and Integrative Health Care(IHC)

The legislative mandate for this Office would be clearly stated, and include but not be limited to the following:

This National Office will have the authority to: oversee, coordinate and direct all federal CAM and IHC activities; and direct and oversee incorporation of CAM and IHC in Federal Benefits Programs. The Office will develop open, structured and ongoing communication pathways among legislators, regulators, reimbursement, consumers, public health, the research community CM, CAM and IHC providers, researchers, educators and organizational representatives and the private and public sector. An Advisory Council and a series of Blue Ribbon Panels will be established. Composition of the Federal Office on CAM and IHC Advisory Council and Blue Ribbon Panels must include representatives from all stakeholder groups, specific health professions and emerging health professions.

This Office shall establish "Blue Ribbon" Panels to advise the now Office and Congress (see above) on CAM and IHC policy and legislative recommendations and to increase communication, education and collaboration among legislators, regulators, federal agency personnel, third party payers and public health; CM, CAM and IHC educators, credentialled CM, CAM IHC, providers, researchers and practitioners; and CAM and conventionally trained Integrated Health Care proponents. The Office will establish and fund joint conferencing and working groups and provide consensus recommendations to the Advisory Council and the Director through the Blue Ribbon Panels in key areas of need, including: *Education and Credentialling, Reimbursement, Clinical Delivery Systems, Underserved and Special Needs Populations, Federal Benefits Programs and Legislation, Product Regulation, and Research.*

In approaching research, this Office shall work cooperatively and collaboratively with the role established by the Title VI – Establishment of the National Institutes of Health National Center for Complementary and Alternative Medicine legislation. This Office, for example, will assist in facilitating communication of additional research needs and recommendations involving education, policy, health services, outcomes, cost effectiveness and field research. The initial Blue Ribbon Panel will be established to address Credentialling, Standards and Education. It is essential that the make-up of all Blue Ribbon Panels be cross disciplinary. In addition, this Office shall have a budget sufficient to carry out these activities.

The Secretary shall establish an Advisory Council for the Office. Membership of the Advisory Council shall be appointed by the Secretary of Health and Human Services in consultation with representative organizations including national complementary and alternative medicine, integrative medicine, public health and world medicine associations, academic consortia and councils (list to be developed). Both the Advisory Council and Blue Ribbon Panels shall be established to include specific representation from the licensed health professions and emerging health professions. In addition to the stakeholder groups mentioned above, at least half of the members shall include practitioners licensed in one or more of the major systems with which the Office is concerned (see NCCAM language-direct quote*). This should include each discipline and system in which accreditation, national certification or a State license is available. At least 3 individuals representing the interests of individual consumers of complementary and alternative medicine shall be appointed. Representatives from conventional medicine, integrative medicine, nursing, public health, selected world medicines, modalities and emerging health care professions will also be established. The Secretary shall designate an individual to serve as the Chair of the Advisory Council. This individual shall also direct and oversee the Office.

The mandates of this Office will include, but not be limited to implementation of the recommendations made to Congress by the White House Commission on Complementary and Alternative Medicine Policy recommendations.

*Title VI NCCAM, Sec 485D Purpose of Center "(e) *Evaluation of various disciplines and systems.* In carrying out subsection (a), the Director of the Center shall identify and evaluate alternative and complementary medical treatment, diagnostic and prevention modalities in each of the disciplines and systems with which the Center is concerned, including each discipline and system in which accreditation, national certification, or a State license is available." (Pp401)

B – Federal Benefits Programs

Examples of agencies with exclusionary language or no mandates:

Services - Indian Health Service policy-restrictive

Services – National Health Service Corps – exclusionary

Centers for Disease Control - Field and Public Health Research - No mandate or appropriation for funding.

Health Care Financing Authority/Medicare - Outcomes Assessment and Cost Effectiveness - exclusionary NIH Institutes for Cancer, Heart, Lung, Blood research need mandates for CAM "offices" for research.

Graduate Medical Education exclusionary – CM professions only

C – Residencies

- Federal Graduate Medical Education (GME) financing systems must pass legislation and or rules authorizing GME funding for licensed naturopathic physician residency training and coverage of ND resident services. The Bureau of Primary Health Care, the Bureau of Health Professions and the Health Resources Services Administration should provide grants to each of the accredited naturopathic medical schools to rapidly expand purely naturopathic residency, specialty and postgraduate training programs and sites as well as exchange opportunities with conventional and other accredited CAM schools.

- The Council on Graduate Medical Education draft report, "*Financing Graduate Medical Education in a Changing Health Care Environment,*" recommended "reform of the entire GME financing structure" (Washington Highlights, Vol.1,No. 35, September 22, 2000). Require an addendum to the report concerning licensed CAM professions and GME financing. GME reforms relevant to both CM and licensed CAM provider services should both be addressed before attempting any major reform to GME systems.

- The professions must receive federal and state funding to establish an adequate number of residency sites. Until funding for graduate medical education is available through the appropriate federal agencies and legislation (HCFA, BPHC, HRSA, GME), it is not appropriate to require this level of training for all naturopathic physicians.

- Postgraduate naturopathic and LCP training should include at least one year of purely naturopathic or LCP residency training.

Groft, Stephen (NCCAM)

From: Kingsbury, Doris (NCCAM)
Sent: Thursday, May 03, 2001 8:33 AM
To: Groft, Stephen (NCCAM)
Subject: FW:

FYI

-----Original Message-----
From: Straus, Stephen (NCCAM)
Sent: Wednesday, May 02, 2001 3:44 PM
To: NCCAM Staff; NCCAM Staff All; Kinsel, Jane (NIAID)
Subject:

Dear colleague:

Today, I am making a number of organizational changes in NCCAM. Although I announced these changes at a special meeting this afternoon in 2 Democracy, some of you are in Chicago, while others of you in Bldg 31 and will not have heard. Therefore, I am writing to summarize the actions so that you hear about them from me personally.

NCCAM is experiencing dramatic growth in funding, in applications, in opportunities, in space and in staff. With such rapid growth come the predictable organizational challenges and stresses. To better meet our present responsibilities the following decisions have been made.

As I indicated at the last "All Hands Meeting", Dr. Jane Kinsel will be joining NCCAM later in May as Associate Director for Science Policy and Operations. Amongst Jane's several responsibilities will be for science reports, coding, all Committee Management, and her serving as Executive Secretary of the Council. Richard has long awaited the opportunity to step aside from these roles and the time is now at hand to thank him for that work and permit him to move forward in his other capacities.

Second, effective immediately, Grants Management, ably directed by Victoria Carper will be moved administratively under the Office of Administrative Operations headed by Camille Hoover. This will bring its day-to-day activities closer to Chris Hollingsworth's Budget Office to facilitate smooth tracking of grant expenditures. At the same time, and with the impending departure of Gene Hayunga to NIAAA, the to-be-named Director of the Office of Scientific Review will report to me directly. Linda Engel will serve as its acting head until our new Chief of Review is on board and up to speed. These latter two changes are in accord with the customary organizational separation throughout the NIH of Grants Management and Review from Program activities.

These changes will also help affect a more horizontal NCCAM organizational structure rather than a vertical one, meaning that there will not be multiple layers of staff each reporting to ones above them. All staff will remain closer to decision making, allowing their voices to be heard more readily throughout NCCAM.

Stephen E. Straus,
Director

Notes from discussion of CAM definition at lunch meeting on March 27th

Key issues:

- Need description of way CAM has traditionally been defined
- Spell out limitations
- Elaborate key words
- Acknowledge fundamental characteristics of CAM systems—e.g., "vitalism"
- Definition needs to include concept of "healing"
- Scope of CAM depends on where one is: "inside" versus "outside"
- Definition that Commission uses must be focused on the outcomes of the report.

Commissions Responsibility:

- To facilitate integration of CAM therapies where evidence dictates
- To establish a process for integration/dialogue/cooperation
- State explicitly that integration is a process

Points of Consensus:

- Commission should not get bogged down in trying to define CAM, but rather should focus on its mission with attention to the legislative language in the Executive Order.
- The Commission needs to develop a strategy and overall philosophy for the report
- The focus of the report needs to be integrative and catholic (i.e., broad-minded)

Next Steps:

Wayne Jonas will meet with the Commission staff to develop language on the Commission's criteria for the scope of the report and to work out a process for developing a mission statement. The Commission staff will put aside some time during the next Commission meeting (in May) to work on the mission statement.

PART II: GUIDING PRINCIPLES AND PERSPECTIVES OF CAM INTERVENTIONS AND PRACTICES

Introduction

The purpose of this part of the report is to provide an overview of the field of complementary and alternative medicine, or CAM. Specifically, is examines the evolution of the definition and how the term is used today. It also examines trends in CAM usage, who uses CAM therapies, what types of CAM modalities are used most frequently and for which condition, and the reasons many people give for using these modalities and approaches and their level of satisfaction. Finally, it examines the paradigm, or worldview, that is common to many CAM systems of medicine and the obstacles that are inherent in attempting to integrate CAM and allopathic approaches with such different worldviews and languages.

What Is CAM?

Ever since the use of medical treatments that fall outside of what is considered mainstream, or conventional, medicine became an internationally recognized phenomenon, various groups have attempted to develop labels and definitions for these therapies. However, as more is learned about what types of therapies are being used, who is using them, and how they are used, the trend has been to broaden these definitions to incorporate new knowledge. The result has been a blurring of the lines between what has traditionally been considered conventional and what it considered to be non-conventional medicine.

Initially terms such as "unscientific" "unorthodox" or "unconventional," were used to describe treatments for which there was not a scientific rationale for how they might work nor any studies of their safety and efficacy (Brody, 1980; Cassileth et al, 1984; Eisenberg et al, 1993). Because many in the medical community perceived that these therapies, such as acupuncture and homeopathy, were being used as alternatives to standard, allopathic health care, they became known collectively as "alternative medicine" in the late 1980s (Furnham and Smith, 1988; Murray and Shepherd, 1988).

However, in the early 1990's a variety of surveys began to demonstrate that people were increasingly using the two systems of medicine--conventional medicine and alternative medicine--side by side, essentially to complement one another (see *Who Uses CAM and What Are They Using?*, below). As a result, the term "complementary medicine" emerged first in Europe and adopted in this country not long afterwards to describe this "other" system of medicine (Ernst, 1995; Joyce, 1994). Yet, even this terminology was unsatisfactory for many because it did not take into account that fact that although many alternative therapies were being used to complement conventional medical care, some were being used *instead* of conventional medical care. Thus, since

the mid-1990s, the phrase "complementary and alternative medicine" has been adopted in the U.S. and Europe to acknowledge this dichotomy.

In an attempt to develop a definition of CAM, a panel sponsored by the Office of Alternative Medicine of the National Institutes of Health (currently known as the National Center for Complementary and Alternative Medicine, or NCCAM), defined CAM as "a broad domain of medical or healing systems that are outside the range of those that are intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp and fixed" (Panel on Definition and Description, 1997).

The Complementary Medicine Field Group of the international Cochrane Collaboration (see Part I) has adopted this definition. However, Cochrane has further broadened the scope of CAM to include "all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture of a given historical period. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp and fixed" (Zolman and Vickers, 1999).

These latter two definitions incorporate a larger worldview than earlier definitions by acknowledging that many health care practices that are considered "complementary" or "alternative" in the United States, such as herbal medicine, are often the main system of treatment in many developing countries (Bannerman et al., 1983; WHO, 1978) and in many ethnic communities in this country (Berman et al, 1999). These definitions also acknowledge that the boundaries between CAM and biomedicine are constantly changing and are likely to evolve even further in the years to come as therapies that are now considered CAM become integrated into mainstream medicine, while new, untested therapies appear on the horizon to take their place.

The NCCAM at the NIH has offered an even more expansive definition of CAM as both "those healthcare and medical practices that are not currently an integral part of conventional medicine" and "those treatments and healthcare practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies" (NCCAM, 2000). This definition potentially includes many approaches to healthcare, including behavioral medicine, preventive medicine, and culturally centered medicine, which are generally accepted as important to overall health care by the conventional medical community but which are not traditionally available in hospitals nor usually reimbursed by medical insurance companies (see *CAM's Focus on Health, Wellness, and Disease Prevention*, below).

Thus, the terminology used to describe unconventional approaches to health and illness has evolved significantly over the past 15 years. Indeed, it began with a rather narrow focus on therapies for which there is a lack of scientific understanding and/or

proof of safety and efficacy to a much broader concept of CAM. Indeed, CAM now includes some therapies where there is a both a general understanding of how they work in addition to significant evidence of proof safety and efficacy. However, many of these therapies have become associated with CAM because, for various reasons, they have been marginalized or underutilized by conventional medicine as critical ingredients to the delivery of high-quality health care.

Rather than attempt to define CAM as what it is not, for the purposes of this report, the Commission has chosen to focus on what it is. Therefore, the Commission has developed a list of common modalities and systems of medicine that are illustrative of the types of CAM treatments and approaches that are encompassed by this report (See Table 1 below).

[Note: This section will be completed after receiving feedback from the Committee on CAM criteria, coordinated by Wayne Jonas].

Trends in CAM Usage

Table 1: Common CAM Therapies and Systems of Medicine

Acupuncture	Chiropractic	Naturopathy
Acupressure	(Sacral) Cranial Osteopathy	Nutritional Therapy
Alexander Technique	Environmental Medicine	Osteopapthy
Applied Kinesiology	Herbal Medicine	Reflexology
Anthroposophic Medicine	Homeopathy	Relaxation and Visualization
Aromatherapy	Hypnosis	Shiatsu
Autogentic Training	Imagery	Spiritual Healing
Ayurvedic Medicine	Magnets	Therapeutic Touch
Energy Medicine	Massage and Bodywork	Traditional Chinese Medicine
	Meditation	Yoga

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

As mentioned in Part I, the use of (CAM) has risen dramatically over the past decade. Between 1990 and 1997, the number of consumers using CAM therapies rose significantly, from 33.8% to 42.1%. (Eisenberg et al.,1998). Some (46.3%) saw a CAM practitioner, but the remaining 53.7% were unsupervised in their use of CAM. During that same time period, the number of people who sought advice from both physicians and practitioners of CAM rose from 8.3% to 13.7%. Surprisingly, only about 40% reported CAM use to their physician, even though 96% had seen their doctor within the past year.

Consequently, expenditures on CAM by Americans have risen dramatically as well, from almost $14 billion in 1990 (Eisenberg et al, 1993) to an estimated $21 billion to $33 billion in 1997 (Eisenberg et al, 1998). The use of herbs was one of the fasted growing categories, with Americans spending an estimated $663 million on medicinal botanicals alone in 1998, compared to $94 million in 1990.

This same survey found that more than 58% of those who used CAM paid out-of-pocket for these treatments and services. As mentioned, total estimated expenses were $21.2—32.7 billion, which is on par with the estimated $29.3 billion out-of-pocket expenses for all United States physician visits (Eisenberg et al, 1998).

Who Uses CAM and What Are They Using?

What are the demographics of CAM usage in the U.S. In 1997, John Astin, Ph.D., then at the Stanford Center for Research in Disease Prevention, asked this question in a nationally representative survey of more than 1,000 randomly selected individuals. This study found people who used CAM therapies were more likely to be college educated (50.6%), aged 35—49 (50.1%), of Caucasian descent (77%), have incomes greater than $50,000 (48.1%), and live in the western United States (501%). The most common medical condition reported among the surveyed subjects was back problems at 24%. Neck problems were associated with the highest use of CAM (57% of patients). The Eisenberg et al surveys (1993, 1998) also have documented that people with chronic pain conditions, including arthritis and headache, and psychological problem (insomnia, depression, and anxiety) are some of the highest users of CAM therapies.

The CAM modalities that patients choose appear to match the medical conditions reported. Eisenberg et al (1998) found, for example, that relaxation techniques, which commonly are used for patients with chronic pain and/or mental conditions, were the most common alternative therapy. Other modalities, such as massage, chiropractic and acupuncture, also are used for chronic pain. People also are turning increasingly to dietary supplements as treatment modalities. Herbal therapies were the second most common therapy with 12.1% of those surveyed reporting use in 1997, up significantly from 2.5% in 199O (Eisenberge et al, 1998).

The following gives a more detailed overview studies of the prevalence of CAM usage in specific patient populations, including: 1) arthritis, 2) back pain, 3) cancer, and 4) HIV:

Athritis

A number of surveys of clinic-based populations taken over the past decade suggest that patients with arthritis and other rheumatologic conditions are frequent users of complementary/alternative medical (CAM) therapies (Boisset and Fitzcharles, 1994; Cronan et al, 1989; Pioro-Boisset et al., 1996; Vecchio, 1994). In fact, these surveys have found that as many as 8 out of 10 rheumatology patients that use clinical services also use CAM therapies to treat their condition. A recent survey by Rao et al. (1999) of patients at a rheumatology clinic revealed a 63% CAM utilization rate, with an average use of 2.5 CAM therapies per patient. This study also found that severity of symptoms predicted the degree of CAM usage. Patients diagnosed with rheumatoid arthritis were more likely to use CAM (38%) compared with those who had osteoarthritis (23%) and fibromyalgia (19%). Half of the patients who tried dietary supplements or vitamins reported some benefit. Only half told their physicians about their use of CAM therapies, however.

Chronic Pain

According to a number of surveys, chronic sufferers are some of the most frequent users of CAM. Indeed, in a national survey, Paramore (1997) found that back neck and shoulder pain were the most frequently cited reasons for visiting a CAM practitioner. In another national survey, Astin (1998) found that the CAM therapies of choice for chronic pain sufferers were exercise, chiropractic, massage, and relaxation techniques. Similarly, in both of their national surveys, Eisenberg and colleagues (1993, 1998) found that CAM therapies were used most frequently by individuals with chronic conditions, including back problems, anxiety, depression, and headaches. In a small survey of people with disabilities, Krauss and colleagues (2000) found that CAM therapies were chosen more often than allopathic therapies by those with physical disabilities for pain (51.8% versus 33.9%), depression (33.9% versus 25%), anxiety (42.1% versus 13.1%), insomnia 32.3% vs 16.1%), and headaches (51.4% vs 18.9%).

Cancer

Cancer patients also are high users of CAM. A recent study by Burstein and colleagues (1999) found that almost 40% of 480 women with stage I or II breast cancer participated in some form of CAM prior to surgery, whereas only about 30% did after surgery. Use of healing and psychological therapies was highest before surgery but tapered off throughout the first year. After 12 months, approximately 50% of women reported new use of both psychological and healing modalities, whereas 45% reported continued use. The use of CAM treatments was not associated with cancer staging or method of treatment. Other studies have reported use of CAM therapies among cancer patients greater than 80% (Bennett and Lengacher, 1999; Richardson et al, 2000). A study of cancer patients enrolled in clinical trials at the National Institutes of Health found that 63% used at least one CAM therapy, with an average use of two therapies per patient (Sparber et al, 2000). Men were significantly less likely to use CAM than women, who were more likely to use numerous therapies. The cancer patients' primary reasons for CAM use included treatment-related medical conditions, such as depression, anxiety, and insomnia. The most frequently reported therapies were spiritual, relaxation, imagery, exercise, lifestyle diet (e.g., macrobiotic, vegetarian), and nutritional supplementation. Patients unanimously believed that these CAM treatments helped to improve their quality of life through more effective coping with stress, decreasing the discomforts of treatment and illness, and giving them a sense of control. Lippert and colleagues (1999) found a similar pattern of CAM usage among men with prostate cancer. This study found that 42% of those surveyed used vitamins, prayer or religious practices, and herbs to treat their condition. The probability of CAM use was independent of treatment modality, but only 17% to 30% reported the use of CAM to their physicians.

Human Immunodeficiency Virus (HIV)

Studies similarly have found that HIV patients are frequent users of CAM. For example, Fairfield and colleagues (1998) surveyed 180 HIV-infected individuals and found more than two-thirds (67.8%) used herbs, vitamins, or dietary supplements. Eighty-one

percent of those who used supplements said these remedies were "extremely" or "quite a bit" helpful. Almost half (45.0%) of this group had visited a CAM provider. In fact, they visited a CAM practitioner an average of 12 times per year, compared to only 7 visits per year to their conventional physician or nurse practitioner. The CAM practitioners they visited most often were massage therapists, acupuncturists or acupressurists. Two-thirds (66%) of those who saw a CAM provider said the provider was extremely or quite helpful. Approximately 24% reported using marijuana to treat weight loss, nausea, and vomiting in the previous year and most (87%) said marijuana said it was extremely or quite helpful. Ominously, 16% of these patients surveyed said they had stopped traditional drug therapy.

Ostrow and colleagues (1997) surveyed 657 HIV-positive individuals in a Canadian clinic population and found that approximately 40% had used some form of CAM, with most using dietary supplements (30%), followed by herbal and other medicinal therapies (22%), tactile therapies (e.g., massage) (22%) had used tactile, and mental relaxation techniques (20%). CAM use was independently associated with younger median age, higher income, and greater physical pain. Interestingly, a slightly earlier study by Singh et al (1996) of CAM use among a population of HIV-positive individuals receiving treatment at a Veterans Affairs medical center Pittsburgh, PA, found that older patients were more likely to use CAM than younger patients, suggesting potential geographic differences in CAM acceptability.

Ethnic Differences in CAM Usage

In addition to the type of illness one has, individual cultural upbringing and ethnicity can influence the type of CAM used. For example, in a study of CAM usage among Mexican-Americans living in the Texas Rio Grand Valley, Keegan (1996) found that 44% of respondents had used a CAM practitioner one or more times during the previous year. In contrast to the national sample surveys, however, the most commonly sought therapies, respectively, for this population were: herbal medicine, spiritual healing and prayer, massage, relaxation techniques, and visits to a curandero (Mexican folk healer). Additionally, in a sample of 104 non-Mexican-American Hispanics adults with diabetes, Zaldivar and Smolowitz (1994) found that 17% of patients reported using herbs to treat their diabetes.

Similar to Hispanics, the Native American populations appear to display a different pattern of CAM usage then the general population. Kim and Kwok (1998) found, for example, in a cross-sectional interview of 300 Navajo patients at an Indian Health Service (IHS) hospital that 62% had gone to native healers and 39% visited them regularly. The factor associated with the least amount of visits was Pentecostal faith. The Navajo were more likely to rely on IHS medical therapy, either alone or with native healers, for physical conditions such as diabetes mellitus, arthritis, abdominal pain, depression, and anxiety. They sought native healers exclusively for traditional issues (family problems, blessings, "bad luck" or "sickness"). Ironically cost was the biggest barrier to seeking a native healer. Native healer costs are approximately 21% of the average Navajo income, whereas care at an IHS clinic or hospital is free.

In a similar study of 150 Native American patients utilizing an urban Indian Health Service clinic in Milwaukee, Wisconsin, Marbella and colleagues found that almost 40% of the patients saw a healer regularly, and of those who do not, most (86.0%) said they would consider seeing one in the future. The most frequently visited healers were herbalists, spiritual healers, and medicine men. Sweat lodge ceremonies, spiritual healing, and herbal remedies were the most common treatments. Not surprisingly, more than a third of the patients seeing healers received different advice from their physicians and healers. Among the patients seeing a healer, the rating of the healer's advice was higher than the physician's advice 61.4% of the time. Only 14.8% of the patients seeing healers tell their physician about their use.

These data suggest that members of minority populations may use CAM therapies differently than the general population. In Mexican-American and Native American populations, in particular, people may rely on those therapies that are more familiar to them or more aligned with their cultural identities. Indeed, these studies suggest that CAM treatments in ethnic populations may be rendered most frequently by traditional healers from the individual's native culture. These studies also raise some serious issues as to the rift between ethnic cultural values and access to native healers. In areas where native healers are available, Mexican-Americans and Native Americans frequent them. Income, not belief systems, prohibits interaction, however (Marbella et al., 1998). Some IHS facilities have addressed this gap by incorporating sweat lodges, or similar spaces, into their facilities and employing native healers (refs?).

Why Do Patients Seek CAM and How is It Used?

It is not surprising that people with chronic painful conditions and psychological disorders, such as anxiety and depression, are frequent users of CAM, because such disorders are complex in origin and, thus, are not easily treated by conventional medicine. Patients experiencing chronic pain often obtain only limited relief from drugs or other medical treatment. Similarly, medicine offers numerous modalities for treating depression and anxiety, but patients may be reluctant to seek medical help, may lack insight into their condition, or may prefer to self-treat. For example, in a survey of 100 patients with panic disorder or agoraphobia, rather than seek conventional medical care, 32% preferred to self-medicate using herbs (Bandelow et al, 1995).

In the Rao et al (1999) survey of rheumatology clinic patients mentioned above, the most common reasons for CAM usage were to alleviate pain and ease their rheumatic condition. Interestingly, 50% of respondents reported turning to CAM because they perceived their drugs as ineffective. Additionally, when Elder and colleagues (1997) interviewed 113 patients at a family practice, the top reason to seek CAM therapies was that they believed they would work. Those who chose to reveal use stated that their physicians accepted their use and respected the patient's desire to have more control over their health.

Although it is not surprising that individuals with chronic, debilitating conditions that are not easily treated by conventional medicine are frequent CAM users, what is surprising is how CAM is being used in relation to conventional medicine. Indeed, until recently, the

prevailing view was that people who use CAM therapies were forgoing effective conventional treatments and thus worsening their illnesses (Dwyer, 1993) primarily because they had turned their backs on science (Skrabenak, 1984; 1988)

However, recent surveys designed to test these hypotheses have found an entirely different picture. In the Astin (1998) survey, only 4.4% of subjects relied primarily on CAM. On the other hand, Astin did find an association between CAM usage and cultural beliefs—specifically, a commitment to environmentalism and feminism, and an interest in spirituality and personal growth psychology. Additionally, the Astin study and others (Fliason, Huchner, & Marchand, 1999; Wagner et al., 1999) have found that a holistic health philosophy, a strong internal locus of control, and transformational life experiences also are associated with CAM usage. Furthermore, similar to the Eisenberg and colleagues' (1998) study, CAM users tended to had a high prevalence of back problems, chronic pain, or anxiety.

Patient Communication with their About CAM Physicians

Why don't many patients tell their health care providers that they are using CAM? In the South Carolina survey (Oldendick et al, 2000), physicians were unaware of CAM use in 57% of their patients using CAM. Patients were least likely to report hypnosis or biofeedback (12.1%), or healing therapies (21.3%). Only 25.8% reported their use of herbal medicine and similar preparations to their physicians, increasing their risk for adverse reactions.

In a survey of health food store customers, Eliason and colleagues (1999) found that these individuals were motivated to pursue wellness and wanted to take responsibility for their health. Although they welcomed a partnership with their physician, they generally believed that their physicians were closed-minded and had little knowledge about dietary supplements. These consumers, therefore, had decided to assess the effectiveness of dietary supplements through personal study and subjective experimentation.

There have been similar findings in patients with cancer. For example, in a survey of women with breast cancer, Adler and Fosket (1999) found that the majority of women (55—85%) use CAM therapies but did not divulge this use to their physicians due to assumed disinterest. Other reasons that the women gave for not divulging CAM use to their physicians included anticipated negative physician response, perceived physician unwillingness and inability to help, irrelevance, the disparate healing strategies between CAM and conventional medicine, and the anticipation that discussion would be too one-sided (i.e., the physician would do all the talking).

These findings are particularly troubling in light of the fact that more and more physicians appear to be open-minded about CAM. For example, in the Consumer Reports survey of more than 46,000 patients using CAM, 60% eventually reported CAM use to their physicians (Consumer Reports, 2000). According to these patients, 55% of physicians expressed approval, with 40% expressing neutrality, and 5% expressing disapproval.

Additionally, in their survey of South Carolina adults, Oldendick and colleagues (2000) found that physicians were most likely to recommend biofeedback or hypnosis (39.3%), self help groups (33.4%), or lifestyle and dietary changes (33.2%). However, only 15.2% of physicians recommended herbal medicine remedies.

In an extensive review of 25 surveys of beliefs of conventional physicians with regard to 5 of the more prominent CAM therapies, Astin and colleagues (1998) found that about half of physicians believed in the efficacy of acupuncture, (51%), chiropractic (53%), and/or massage (48%). However, only 13% believed in using herbal therapies. Approximately 40% had referred patients to either an acupuncturist or chiropractic practitioner, whereas 20% referred patients for massage therapy.

Patient Satisfaction With CAM

How does patient satisfaction with CAM therapies compare to conventional therapies? In their survey of 1584 South Carolinian adults, Oldendick and colleagues (2000) found that approximately 68% perceived their therapy to be effective or very effective, depending on the specific modality Those working with spiritual healers were most likely to report satisfaction (79%), whereas those participating in weight loss programs reported the least satisfaction (44.9%). People involved in herbal medicines, folklore remedies, vitamins, and homeopathy reported a 62% satisfaction rate.

In the Consumer Reports' (2000) survey mentioned above, 23% of those trying herbs and dietary supplements reported feeling much better. This rate was comparable with levels of satisfaction found with both mind-body techniques and over-the-counter drugs, but was inferior to satisfaction with prescription drugs (50%). Satisfaction levels varied widely depending on medical condition and therapy. Patients with some of the difficult-to-manage medical conditions, including back pain, neck pain, and fibromyalgia, reported CAM therapies to be comparable with standard medical care.

World View of Major CAM Traditions

CAM therapies may differ from conventional medicine not only in their methods but also in some of their underlying philosophies. The way that many CAM disciplines define health, illness, and the healing process can depart significantly from the beliefs that underlie the practice of allopathic medicine. It is essential to consider the different paradigms from which conventional medicine and CAM approach healthcare as these have implications for research and integration (see below).

Most of the world's traditional healing systems—Traditional Chinese Medicine (TCM), Indian Ayurvedic Medicine, Persion Urami, and Native American Medicine—are based on the assumption that we humans are connected to one another, to the earth, and the spiritual world in many more ways than science has yet uncovered. Disease, in these

systems of medicine, is an imbalance within our bodies as well as between the way we live and the natural, social, and spiritual world (Gordon, 1996).

Even CAM modalities that are not directly evolved from these traditional systems of medicine, such as chiropractors and homeopaths, have adopted such beliefs as well as the notion that the body had the innate ability to heal itself. According to this philosophy, which is referred to as *vis medicatrix naturae* (the healing power of nature), the body's self-healing mechanism can be speeded up, sometimes to an astonishing degree, by the proper stimuli. Thus, many CAM practitioners employ therapies designed to stimulate the patient's constitution to fight on its own behalf, on the assumption that this emphasis on enhancing the natural healing process is the most appropriate foundation of any medical therapy (House of Lords, 2000).

CAM's Focus on Wellness and Disease Prevention

Many CAM therapies emphasize "wellness" as not only being the absence of disease but also with attributes such as good energy (vitalism), happiness, and a sense of wellbeing as being more central goals of intervention (House of Lords, 2000). Moreover the emphasis of much of CAM is often on strengthening the whole organism rather than directly attacking the pathology (such as an infection or tumor). CAM therapies use different vocabularies to understand these emphases, with treatment concepts such as detoxification and tonification, and with different cultural concepts of "energy" as recuperative forces in the body (notably in forms of medicine originating in Asia) (House of Lords, 2000).

Most CAM therapies also apply a non-Cartesian view of health, making less distinction between the body, mind, and spirit as distinct sources of disease. The language used in CAM often tends to imply that all these dimensions of the human condition should be viewed in the same therapeutic frame. This is different from the conventional medical approach, which often involves prescribing a standard drug and a similar treatment regime for patients with the same underlying pathology.

Another unifying thread that runs through many CAM approaches is a focus not only on restoring balance to those who are sick but also in addressing the underlying causes of the imbalances that have made them sick in the first place. CAM therapies also take a highly individualistic approach to treatment, in which patients may receive a combination of treatments specifically tailored to their needs. Therefore, many CAM practitioners often prescribe a package of care, which could include modification of lifestyle, dietary change, and exercise (House of Lords, 2000). For example, a chiropractor, in addition to providing a spinal adjustment, may also offer advice on diet and exercise, provide guidance on breathing and relaxation, and prescribe nutritional supplements.

As noted earlier in this chapter, an emphasis on disease prevention and wellness is not the sole domain of CAM. In fact, conventional medicine has a long tradition of being concerned with maintaining health and preventing disease. Unfortunately, however, medical schools, for the most part, have not placed a great deal of emphasis on preventive medicine and education on wellness. In fact, a recent survey by Garr and colleagues (2000) of 144 allopathic and osteopathic medical schools found a greater emphasis on teaching and evaluating medical students' knowledge in the areas of clinical preventive services and quantitative methods, and less emphasis on the community dimensions of medical practice and health services organization and delivery. More revealing, however, was the finding that fewer than half of all respondents were satisfied with the quality of their assessment of student achievement in any of the four domains of prevention education. More than 30% of the medical schools expressed a desire to receive assistance with designing curricula and/ or evaluation methods in prevention education.

In addition, given the prevalence of nutritionally related chronic diseases in American society, it would seem imperative that the training of physicians should include a focus on the relationship of diet to disease. Yet, despite scientific data, public interest, US government reports, society studies, and congressional mandates, according to a recent report by the National Education Consortium (1997), the teaching of nutrition in medical schools and residency programs remains "woefully inadequate." Indeed, most medical schools do not have faculty trained specifically in nutrition (Cooksey et al, 2000), and faculty resistance to changing medical school curricula is a major barrier to overcome in the effort to expand such education (Armstrong & Koffman, 1998).

Therefore, a core emphasis on wellness and disease prevention appears to be a significant difference between a number of CAM systems of medicine and allopathic medicine, at least in terms of medical education.

Obstacles Integration of CAM Approaches and Treatments into Allopathic Medicine

As the popularity and the evidence base for CAM has grown, so has interest and belief in CAM among allopathic physicians and medical institutions. Astin et al (1998), for example, conducted a comprehensive review of 25 surveys of physician practices and beliefs with regard to five of the more prominent CAM therapies—acupuncture, chiropractic, homeopathy, herbal medicine, and massage--and found that about half of the surveyed physicians in these studies believed in the efficacy of these CAM therapies. Surprisingly, a significant proportion were both making referrals to CAM practitioners as well as offering some of the CAM treatments in their own practice.

This increasing acceptance of CAM among allopathic physicians has fueled a movement to "integrate" those CAM modalities with the best evidence of effectiveness with the best of allopathic medicine. This integrative medicine movement seeks to sort through all of the evidence about all healing systems and try to extract and integrate those ideas and practices that are useful, safe, and cost effective. The ultimate goal is to merge

them into a new, more comprehensive, compassionate, and effective model of care that includes both the precision and power of biomedicine and the wisdom of other healing traditions (Gordon, 1996). According to some (Weil 2000), such an integrated system of medicine would have a strong evidence base but also would sensitive to consumer demand.

However, there is significant debate in the allopathic medicine community on how this new model of care would be implemented. One of the models of integration, which is being tested at a small but growing number of allopathic medical institutions, is to have allopathic and CAM practitioners working side-by-side, collaborating both in the diagnosis and treatment of patient conditions (Muscat, 2000). While promising, this model of integration faces significant obstacles. Indeed, as mentioned, allopathic medicine and CAM practitioners often have entirely different worldviews regarding health and disease and, thus, employ a completely different vocabulary and grammar. Most allopathic practitioners have little understanding of CAM diagnostic terms, such as Qi (the Chinese term for vital energy) or doshas (the Ayurvedic term for mind-body type). Sometimes familiar terms are used but with a different meaning: acupuncturists may talk of "taking the pulse," but they will be assessing characteristics such as "wiriness" or "slipperiness," which have no Western equivalent. It is important not to interpret terms used in CAM too literally and to understand that they are sometimes used metaphorically or as a shorthand for signs, symptoms, and syndromes that are not recognized in conventional medicine.

By the same token, few CAM practitioners have a thorough understanding the theories and terms associated with allopathic medicine. Indeed, few CAM disciplines have significant exposure to fields such as pathophysiology, epidemiology, molecular biology, and other sciences that allopathic physicians receive training in during the medical school apprenticeships. In such a climate, basic communication, much less collaboration, is almost impossible (Caspi et al, 2000).

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

CAM practitioners also are not generally concerned with understanding the basic scientific mechanism of their particular therapy. Instead, their knowledge base is often derived from a tradition of clinical observation. Sometimes traditional teachings are handed down in a way that discourages questioning and evolution of practice, or

encourages reliance on their own and others' individual anecdotal clinical and intuitive experience.

Therefore, even for those CAM therapies proven to be safe and effective, it should be stressed, however, that the lack of a shared worldview is not necessarily an insurmountable barrier to effective integration. For example, doctors have work closely alongside hospital chaplains and social workers for decades, each regarding the others as valued members of the healthcare team.

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From: Starke-Reed, Pamela (NIDDK)
Sent: Thursday, March 15, 2001 8:30 AM
To: Abbott, David (NCCAM); Albrecht, Joan (NCCAM); Axelrod, Corinne (NCCAM); Baron, Christopher (NCCAM); Batten, Willer (NCCAM); Bellamy, Carolyn (NCCAM); Benjumea, Olga (NCCAM); Bersofsky, Yvonne (NCCAM); Blackman, Marc (NCCAM); Briggs-Hall, Sylvester (NCCAM); Camilo, Rick (NCCAM); Carlisle, Alice (NCCAM); Carlson, Susan (NCCAM); Carper, Victoria P. (NCCAM); Chah, John (NCCAM); Chang, Michele (NCCAM); Colvin, Odessa (NCCAM); Ehrler, Karla (NCCAM); Engel, Linda (NCCAM); Evans, Marguerite (NCCAM); Fish, Chris (NCCAM); Fisher, Ken (NCCAM); Fitzpatrick, Carol (NCCAM); Flowers, Susan (NCCAM); Geater, Russell (NCCAM); Goertz, Christine (NCCAM); Grechko, Elena (NCCAM); Greene, Anita (NCCAM); Groft, Stephen (NCCAM); Haller, Lawrence (NCCAM); Hayunga, Eugene (NCCAM); Hazleton, Nancy (NCCAM); Hines, Rhonda (NCCAM); Hodgkins, Carolyn (NCCAM); Hollingsworth, Christine (NCCAM); Hoover, Camille (NCCAM); Hrolenok, Paul (NCCAM); Hussey, Doug (NCCAM); Jackson, Morgan (NCCAM); Kaczmarczyk, Joseph (NCCAM); Kingsbury, Doris (NCCAM); LeBlanc, Stephen (NCCAM); Liu, Irene (NCCAM); Madden, Kathleen (NCCAM); Manley, Diana (NCCAM); Markham, Dennis (NCCAM); Maryland, Cecelia (NCCAM); Maynard, Bryan (NCCAM); Miller, Maureen (NCCAM); Mohseni, Ilze (NCCAM); Montoro, Roberto (NCCAM); Mulach, Barbara (NCCAM); Nahin, Richard (NCCAM); O'Donnell, Ellen (NCCAM); Pearson, Nancy (NCCAM); Pinkney, Maliaka (NCCAM); Pitts, Marc (NCCAM); Pollen, Geraldine (NCCAM); Rafferty, Steve (NCCAM); Richardson, Mary Ann (NCCAM); Rodriguez, Ivelisse (NCCAM); Rollwagen, Florence (NCCAM); Rosario, Joana (NCCAM); Sabatos, Charles (NCCAM); Schafer, Amanda (NCCAM); Standberry, Andra Allen (NCCAM); Stidham, Diane (NCCAM); Straus, Stephen (NCCAM); Tucker, William (NCCAM); Tyler, Robbie (NCCAM); Unger, Carol (NCCAM); Villone, Shirley (NCCAM); Vu, Tung (NCCAM); West, Neal (NCCAM); Whccamp (NCCAM); Whichard, Kerry (NCCAM); Wise, Allison (NCCAM); Wong, Shan (NCCAM); Wongsam, Andrea (NCCAM); Wuhib, Mentwab (NCCAM)
Subject: FW:

Subject: MARCH IS NATIONAL NUTRITION MONTH

Overweight and obesity are major health problems, affecting nearly 97 million adults in the US and many others worldwide, including children and adolescents.

Who should lose weight?
Adults who are overweight or obese can improve their health by adopting eating and physical activity patterns that they maintain for life. Adults who are overweight or obese and have diabetes, heart disease, high blood pressure, high cholesterol levels, high blood sugar levels, or a family history of such problems, can benefit from a weight loss as small as 10 to 20 pounds. Cutting back on 500 calories a day amounts to 3500 calories in a week which equals 1 pound of body fat.

What about physical activity?
Regular physical activity helps you lose weight and build an overall healthy lifestyle. Physical activity increases the number of calories your body uses and promotes the loss of body fat. People who include physical activity in their weight-loss programs are more likely to keep their weight off than people who only change their diet. Physical activity also improves your strength and flexibility, lowers your risk of developing heart disease and diabetes, helps control blood pressure and blood sugar, promotes a sense of well-being, and decreases stress.

Where to go for information?
Try NIDDK's Weight-control Information Network (WIN) <<http://www.niddk.nih.gov/health/nutrit/nutrit/htm>>. You will find a listing of educational materials to read and print out for your use. You

may also obtain free copies of these materials by calling WIN at 202 828-1025 (877 946-4627) or by sending an email message to <win@info.niddk.nih.gov <mailto:win@info.niddk.nih.gov>>.

NHLBI's Aim for a Healthy Weight Website <http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/control.htm> has information on calculating body mass index (BMI), assessing risk status, and controlling weight based on the Clinical Guidelines on Overweight and Obesity in Adults. For publications on overweight, high blood pressure, high blood cholesterol levels, or other risk factors for heart disease, contact the NHLBI Information center at 301 592-8573.

Albrecht, Joan (NCCAM)

From: Kathy Eldrid [pnet8@yahoo.com]
Sent: Monday, March 19, 2001 7:32 AM
To: Barbara Groves; G ; SENATOR Tom Harkin; SENATOR Orrin Hatch; Citizens for Health; Dianne Heino; Mail, Hhs (HHS/OS); SENATOR James Inhofe; Congressman Ernest Istook, Jr.; Whccamp (NCCAM); New England" "Journal of Medicine; ME Gov. Angus King; SENATOR Thomas D.; SENATOR Tom Daschle; Craig Freshley; Jeannie G., editor; Surgeon General Website, None (HHS/OS); Meredith Goad
Subject: An M.D. is contacting "Montel Williams" for Kathy Eldrid, R.N.

--- Kathy Eldrid <pnet8@yahoo.com> wrote:
> Date: Sun, 18 Mar 2001 15:54:27 -0800 (PST)
> From: Kathy Eldrid <pnet8@yahoo.com>
> Subject: Ken, thanks for contacting
> www.sarcomaalliance.com
> To: HOPE2 <hope@hopehealing.org>
>
> Dear Ken, I thank
> you
> for checking out www.sarcomaalliance.com and my
> "Personal Story". You already know it but that the
> founder of that site asked me pesonally, to write
> it,
> as an R.N., was a GIFT to me. I told her ahead of
> time, it would not be the "norm" and she was welcome
> to check on all the facts first before publishing
> it.
> When I finally finished writing it and e-mailed it
> to
> her (in CA), she posted it in less than 24
> hours!!!!!!!!! Even though she and I have different
> sarcomas, this is actually irrelevant, and our
> treatment paths are obviously different, she has
> managed to live the same 8 years and is also an R.N.
> I
> already know she is on a Mission, the same as
> myself.
> So, I admire her from a far.
>
> What saddens me are the doctors who are logging on
> to
> that web site looking for answers for their own
> patients who have these difficult sarcomas to treat.
>
> What does that tell you? We most definitely
> NEED
> to move into the future with all cancer treatment,
> and
> NOW. It is already way over due!!!!!! And, we, the
> patients are dying, not because we don't have the
> answers, but because we DO and we have the
> "scientific
> evidence". I thank God I became a nurse, because it
> is
> to this "scientific evidence" I pay attention. Have
> done my homework.
> You
> perhaps have no idea what it means to me that you,
> as
> an M.D., will contact the "Montel Williams" show on

> my
> behalf. You have a copy of the "scientific
> evidence".
> It is my 200 page, 4 year medical record from the
> late, James McCoy, Ph.D. He was far beyond the rest,
> as is Rhett Bergeron, M.D., in Stockbridge, GA.
>
> I thus far, have $3,500 toward the
> estimated
> $15,000-20,000 I will need for successful cancer
> treatment. It will be light years before any, if
> ever,
> insurance companies cover this. And,
> sadly, we all know the reasons. It is due to our
> current political/medical "systems" created some
> time
> ago with the idea of protecting us, but has most
> certainly lost all perspective and logical thinking.
> When ever there is a war declared on anything, it is
> doomed to fail. Such as the war on drugs, the war on
> cancer, etc...War does not determine who is right,
> war
> determines who is left. Thanks from my heart.
> Love=Labor Of Vast Entity. Kathy
>
> _____
> Do You Yahoo!?
> Get email at your own domain with Yahoo! Mail.
> http://personal.mail.yahoo.com/
>

_____
Do You Yahoo!?
Get email at your own domain with Yahoo! Mail.
http://personal.mail.yahoo.com/

Whccamp (NCCAM)

From: pnet8@webtv.net
Sent: Thursday, March 15, 2001 9:18 AM
To: Administrator@mccain.senate.gov; acsaction@cancer.org; kwiley@mdanderson.org; NCI CIPS Cancermail Request; Burg, Cheryl (NCI); canclub@primenet.com; cfh@citizens.org; andersoncm@health.missouri.edu; istook@mail.house.gov; baldacci@me02.house.gov; ok01.largent@mail.house.gov; rep.tomallen@mail.house.gov; chc@mdf.org; Mail, Hhs (HHS/OS); dheino@mdf.org; copingmag@aol.com; gustav@imsdd.meb.uni-bonn.de; gayle.a.bagley@state.me.us; Whccamp (NCCAM); dateline@NBC.com; jguttman@pressherald.com; info@cancerresearch.org; newshour@pbs.org; Kevin.w.concannon@state.me.us; boehml@health.missouri.edu; cfwintner@aol.com; malindollinger@earthlink.net; 75430.665@compuserve.com; governor@state.me.us; megan.hannan@cancer.org; mgoad@pressherald.com; First.Lady@whitehouse.gov; NIHInfo (OD); president@whitehouse.gov; ima_me01iq@mail.house.gov; rose.smith@state.me.us; senator@nickles.senate.gov; senator@clinton.senate.gov; senator_mccain@mccain.senate.gov; jim_inhofe@inhofe.senate.gov; Senator@biden.senate.gov; senator_leiberman@lieberman.senate.gov; john_mccain@mccain.senate.gov; senator_hatch@Hatch.senate.gov; senator@collins.senate.gov; senator_daschle@exchange.senate.gov; tom_daschle@daschle.senate.gov; tom_harkin@harkin.senate.gov; hullenderd@health.missouri.edu; Nightly@NBC.com; Surgeon General Website, None (HHS/OS); uhcan@uhcan.org; vice.President@whitehouse.gov; sf.nancy@mail.house.gov; hazel.raynesdesilets@libertymutual.com; webmail@specter-iq.senate.gov; NCI ICIC CIS MAIL; olympia@snowe.senate.gov; senator_specter@specter.senate.gov; general@washtimes.com; governor.jesseventura@mail.state.mn.us; webeditors@newsweek.com; efarah@worldnetdaily.com
Subject: Impending death of 22 yr. old, Douglas H., in MI, with PNET.

Impending death of 22 yr. old,...

Please Read All Enclosed Forwards.

Kathleen R. Eldrid, R.N.
10 Mt. Pleasant Street
Biddeford, Maine
04005
U.S.A.
(207) 282-2050

Kathy

Whccamp (NCCAM)

From: pnet8@webtv.net
Sent: Wednesday, March 14, 2001 9:11 AM
To: acsaction@cancer.org; cfh@citizens.org; istook@mail.house.gov; baldacci@me02.house.gov; ok01.largent@mail.house.gov; rep.tomallen@mail.house.gov; chc@mdf.org; andersoncm@health.missouri.edu; Mail, Hhs (HHS/OS); dianelee8 @yahoo.com; dheino@mdf.org; copingmag@aol.com; gustav@imsdd.meb.uni-bonn.de; gayle.a.bagley@state.me.us; GSELI146@foxinc.com; Whccamp (NCCAM); dateline@NBC.com; jguttman@pressherald.com; info@cancerresearch.org; newshour@pbs.org; Kevin.w.concannon@state.me.us; boehml@health.missouri.edu; andersonm@mercyme.com; governor@state.me.us; megan.hannan@cancer.org; mgoad@pressherald.com; First.Lady@whitehouse.gov; NIHInfo (OD); president@whitehouse.gov; ima_me01iq@mail.house.gov; rose.smith@state.me.us; senator@nickles.senate.gov; senator@clinton.senate.gov; senator_mccain@mccain.senate.gov; jim_inhofe@inhofe.senate.gov; Senator@biden.senate.gov; senator_leiberman@lieberman.senate.gov; john_mccain@mccain.senate.gov; senator_hatch@Hatch.senate.gov; senator@collins.senate.gov; senator_daschle@exchange.senate.gov; tom_daschle@daschle.senate.gov; tom_harkin@harkin.senate.gov; hullenderd@health.missouri.edu; Nightly@NBC.com; Surgeon General Website, None (HHS/OS); uhcan@uhcan.org; vice.President@whitehouse.gov
Subject: "Montel Williams" e-mail address below. HELP SAVE KATHY ELDRID, R.N.

Montel Show's e-mail address.....

MY HEALTH INSURANCE DOES NOT COVER MY CANCER TREATMENTS!!!!!!!!

Kathleen R. Eldrid, R.N. 10 Mt. Pleasant Street Biddeford, Maine 04005 U.S.A.

Kathy

Whccamp (NCCAM)

From: pnet8@webtv.net
Sent: Wednesday, March 14, 2001 7:53 AM
To: bocababy1@aol.com; amyelizabeth227@email.msn.com; abruin@ulink.net; bertellebrooking@hotmail.com; dbuckley@maine.rr.com; mcleodbetty@hotmail.com; betty_s._mcleod@onf.com; poohdr@yahoo.com; healingvisions@cybertours.com; Carrietaz526@aol.com; ceciletougas@yahoo.com; cselig@pasco.k12.fl.us; christineb11@hotmail.com; Eastpromgirl@aol.com; daksi@hotmail.com; ddash@spurwink.org; dghpolarity@pivot.net; deedee_156a@yahoo.com; dongin7@bellsouth.net; hddesilets@yahoo.com; brucemanke@yahoo.com; jjb128@aol.com; francine.roy23@sympatico.ca; george.v.kampfer@verizon.com; hmrdesilets@yahoo.com; jackie@cybertours.com; jadehare@aol.com; rtede5296@aol.com; monteith1@juno.com; jbmurphylcpc@hotmail.com; jmwexler@yahoo.com; joe_gerber@hotmail.com; catspaw@cybertours.com; newedgevents@hotmail.com; jsnyder@javanet.com; jhs@sphinxtek.com; mingisart@hotmail.com; katrina4158@aol.com; brulin@loa.com; essiac@mediaone.net; kalika@cybertours.com; gilson@msu.edu; lisadav@cwnet.com; lyng12072@aol.com; margoss43@aol.com; andersonm@mercyme.com; earth@loa.com; mdibmr@aol.com; marquardt@mail.com; nmay1@home.com; plg@cybertours.com; patricr@juno.com; pyegge@journaltribune.com; weave@bellatlantic.net; rwharris@aol.com; rebeccadunnells@hotbox.com; ricramrattan@aol.com; hiiakamercy@hotmail.com; maryro@yahoo.com; sdwhitney@hotmail.com; CHANDLER5@msn.com; sclemens42@hotmail.com; romanoff@usm.maine.edu; susaneddoughty@aol.com; TPrkr@cs.com; nogr@earthlink.net; tracy@troiano.net; valerie.whittier@state.me.us
Subject: Montel Show's e-mail address..

Montel Show's e-mail address.....

Dear supporters, If you have not already contacted the "Montel Williams" show on my behalf, the fastest, easiest method appears below in forwarded e-mail. Also, you can read my Personal Story at www.sarcomaalliance.com Time is of the essence. I have been deeply touched by all of your letters, thus far. Together, we can. Alone, we cannot. Love=Labor Of Vast Entity

Kathy

WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

Original Budget 10/01/99 - 09/30/01		**Proposed Budget** 10/01/99 - 03/07/02
Staff/Consultants Personnel and Benefits	$1,195,000	$1,175,000
Commission Meetings (travel, Per Diem, Honorarium)	(8) 640,000	(10) 800,000
Services and Supplies (telecommunication, copier, meeting supplies, space rental, journals, renovations, commission Administration)	165,000	165,000
Town Hall Meetings	(0) 0	(4) 200,000
Website Development and maintenance	0	135,000
Contract Expenses, Logistics Support Media/Public Contact	0	260,000
Commitments of WHCCAMP Prior to 06/30/00 (all of above)	2,000,000	256,000 $2,996,000

Additional Expenses for Commission's Activities	
Internet Website Development and Maintenance	$135,000
Town Hall Meetings (4)	200,000
Additional Meetings of Commission (2)	160,000
Additional Members (5)	40,000
Honorarium for Commission Member ($469)	51,000
Expenses Incurred before 06/30/00 (Salaries, benefits of previous staff)	105,000
Additional Staff/Expenses from 10/01/01-03/07/02	300,000
	$991,000

Summary of Major Themes from Town Hall Meeting: Seattle, October 30-31, 2000

- Tie into the goals of Healthy People 2010, the Federal blueprint for public health.

- Facilitate collaboration...
  (1) between conventional and CAM practitioners;

  (2) among local, regional, state, and Federal government agencies (including regulators, licensing boards, public health officials, and community-based primary care facilities); and

  (3) with 3rd party payers.

- Identify obstacles slowing the incorporation of evidence-based CAM practices into mainstream practice. Address, through collaboration, lack of familiarity with CAM research and researchers, suspicion of CAM therapies, and mistrust of CAM practitioners and researchers. This is often difficult and a challenge for both communities.

- Strengthen accountability and develop uniform, high quality standards; consistent licensing procedures; and practice guidelines as the basis for the inclusion of CAM practitioners in Federal, state, and regional/local health programs; to ensure uniformity of services for reimbursement; and to allow patients freedom of choice.

- Develop public or private quality assurance programs to increase provider and public trust in CAM products.

- Develop an herbal pharmacopoeia with standardization and regulation of manufacture, similar to the homeopathic pharmacopoeia.

- Support with local, state, and Federal funds primary health care clinics that can serve as incubators for cross training and integrating multiple-practice approaches, and for stimulating other collaborative and relationship-building activities. Integrate CAM into community health center networks nationally.

- Increase Federal agency support for local community demonstration projects to integrate CAM into conventional health services.

- Eliminate arbitrary exclusions, avoid mandates, and focus benefits on scientific outcomes in state health programs.

- Reduce the disparity in funding for research on conventional medical modalities and on CAM practices and products; increase funding to CAM professional schools for research and research training. Fund planning grants to CAM academic centers to develop research agendas, etc. Issue an RFA to support research infrastructure at CAM

institutions. Establish collaborative relationships with universities and hospitals that have needed facilities and expertise.

- Increase funding for education and training at CAM institutions and at traditional universities, including schools of medicine, nursing, dentistry, pharmacy, public health, and veterinary science. Train CAM professionals in public health.

- Develop methodologies to study emerging unconventional healing practices. Find methodologies that accommodate the cultural context and patient-centered, unique questions posed by some CAM therapies. When placebo-controlled trials are not feasible or appropriate, employ practice-based outcomes research, best case series, clinical audits, cohort analysis, pattern recognition, statistical evaluation, multi-varied or cluster analysis, and other known or new methods. Start with practical health services trials as a basis for further study.

- Include CAM professionals on research advisory councils, regulatory boards, review committees, and policy groups.

- Educate IRBs to provide more informed oversight of CAM clinical research.

- Examine regulations that lead to the removal of licenses of CAM practitioners and intimidate collaborating allopathic physicians.

- Study wellness, the effect of social context on health, quality of life measures, and cost effectiveness of CAM.

- Increase research support to provide valid chiropractic clinical outcomes data. Support researchers and infrastructure at colleges of chiropractic. Integrate chiropractic research and education programs in conventional higher education environments.

- Allow for continuum of care as part of collaboration between allopathic and CAM care.

- Increase research on CAM as an alternative to conventional approaches that are not successful or create adverse reaction risk, especially for chronic conditions.

- Be more proactive to ensure that CAM research findings reach a broader audience.

- Support National Library of Medicine indexing of CAM journals.

- Determine the distinctions between incorporation of CAM procedures into conventional medical practice and integration of CAM providers into patient care pathways.

- Design services for reaching and covering the underserved; evaluate utilization by the underserved.

- Expand Federal laws to include loan repayment and scholarships for some CAM professions to serve in underserved areas.
- Include CAM in Medicare, Medicaid, and other Federal and state health-related program coverage.
- Improve collaboration among payers, the research and regulatory communities, and the professions.
- Fund research on insurance company CAM databases and how CAM affects health care costs.
- Evaluate insurance data from the Washington state experience.
- Examine the effect of insurance coding and "medical necessity" as limitations on CAM.
- Investigate reimbursement for herbal practice in states with practice standards.
- Work toward insurance coverage in private, Federal, and state plans to provide access to licensed CAM providers and to cover (approved) substances prescribed and certified as part of treatment.
- Conduct regional conferences on CAM integration.
- Strengthen Federal role as facilitator, partner, and referee.

Prepared by GPollen (11/28/00)

Specific Recommendations from December, 2000, WCCAMP Meeting

Panel 1: Clinical and Cost Effectiveness of Selected CAM Services

- Examine three major reports on the cost-effectiveness of chiropractic as part of the Commissions deliberations. (**William Meeker, chiropractor**)

- Provide greater funding for the NCCAM. (**Konrad Kail, naturopath**)

- In language for CAM in Federal entitlement acts, such as Medicare, Medicaid, Indian Health Service, and CHAMPUS for the military. (**Konrad Kail, Naturopathic Physician**)

- Increase research expenditures on the clinical efficacy of acupuncture in conditions such as musculoskeletal pain and analgesia, breech aversion, nausea and vomiting, dysmenorrhea (menstrual pain), and bladder disorders. (**Patricia Culliton, Licenced Acupuncturist, LAc**)

- Funding for large clinical effectiveness study and cost effectiveness studies of acupuncture for specific conditions as well as the development of CME courses and CEU courses for physicians in acupuncture and for CAM modalities and approaches in general. (**Patricia Culliton, LAc**)

- Direct education resources to training medical students and physicians in the effectiveness and cost benefits of CAM approaches as opposed to delivering the modalities themselves. (**Patricia Culliton, LAc**)

- Train all health professionals, not just medical doctors, but CAM professionals as well, in how to interrelate to each other. (**Patricia Culliton, LAc**)

- Develop a school loan forgiveness program for those people going to acupuncture schools, if they commit themselves to work in public health agencies after graduation. (**Patricia Culliton, LAc**)

- Institution a system, such as that proposed by the World Health Organization, to establish guidelines for the assessment of herbal medicines and to ensure proper identity and quality of both raw materials and finished products. (**Dennis Awang, Ph.D., herbalist**)

- Encourage FDA to require nutritional supplement and herbal remedy manufacturers to put labels on their products warning against possible adverse effects or toxicity, and recommendations for proper usage. . (**Dennis Awang, Ph.D., herbalist**)

- Involve well-trained herbalists be in studying the safety and efficacy of herbs on a scientific basis because many scientists have the view that herbs do not work until it is proven that they do work, which is the antithesis of how an herbalist would view them. (**Christopher Hobbs, herbalist, licensed acupuncturist**)

- Require the FDA to recognize a "trad itional medicines" category that would take into account the historical and traditional use of an herb and to better educate consumers how to use them. Under such a system, manufacturers would be allowed to put the information on the known effects of nutritional supplements on the label so that it would greatly enhance both the effectiveness and the safety. (**Christopher Hobbs, herbalist**)

- Improve teaching of nutritional information in medical schools. If implemented, the cost of care will undoubtedly come down by billions of dollars. (**Alan Gaby, M.D., nutritionist**)

- Support the passage of legislation currently in Congress, H.R. 1187 and S. 660, to provide outpatient medical care coverage for medical nutrition therapy for diabetes and kidney disease. (**Patsy Brannon, Registered Dietition, R.D.**)

- The expansion of Medicare and Medicaid coverage as recommended by the Institute of Medicine report for the treatment chronic diseases for which

nutritional therapy has been documented to be effective. (**Patsy Brannon, R.D.**)

Panel 2: Use of CAM for Selected Health Conditions

- The development of "pe er" education programs to disseminate credible information on CAM to minority and ethnic communities. (**Denise Drayton, Exponents**)

- "Lifestyle behavior changes" should be lis ted as a prudent, first-choice medicine for people with heart disease. (**Richard Collins, cardiologist and Director of the Heart Disease Reversal and Prevention Program**)

- Embrace nutritional programs such as the Dean Ornish program by providing access to it for all populations. (**Richard Collins, cardiologist**)

- The development demonstration projects around the country that will allow hospice programs to provide care without a reimbursement cap and without a criteria or prognostic cap. (**J. Donald Schumacher, Center for Hospice and Palliative Care**)

Panel 3: Issues in Integrating CAM in Service Delivery

- Fund organized systematic reviews in a coordinated fashion on specific CAM methods and by clinical conditions. (**Harley Goldberg, D.O., Medical Director for CAM for Kaiser Permanente**)

- Increase research on the clinical implementation of specific CAM treatments for specific conditions. This research should involve CAM practitioners and experienced clinical researchers. (**Harley Goldberg, D.O., Kaiser Permanente**)

- Recommend passage of The Access to Medical Treatment Act, which would make it possible for experimental "non-toxic" tr eatments to be tried under strictly controlled circumstances. (**Berkeley Bedell, president of the National Foundation for Alternative Medicine, NFAM**)

- Allow use of any medical treatment that has been in use in another country, where there is no evidence of it posing a danger to the patient. Because there are not good treatments for most degenerative diseases, people with such conditions should have the right to try potentially beneficial treatments developed in other countries with out fear of government interference. (**Berkeley Bedell, NFAM**)

- All CAM research should be conducted by neutral observers who are objective and impartial, neither strong negative skeptics, nor strong proponents, but people who are committed to scientific research. (**Paul Kurtz, Ph.D., The Committee for the Scientific Investigation of Claims of the Paranormal**)

Panel 4: Meeting Public Needs/Systems of Delivery

- The Federal government should use the investigation of CAM as an to solve its most pressing health problem: controlling spiraling health care costs. (**Robert Atkins, M.D., private practice physician**)

- Promote the kind of research that will allow conventional and CAM to be compared side by side with a matched group of subjects to determine which gets better results and at lower costs. . (**Robert Atkins, M.D.,**)

- Any policies that the Commission recommends should not be biased in favor of full integration of CAM therapies into mainstream medicine. (**Mort Rosenthal, chairman and founder of Well Space, a for-profit CAM clinic**)
- Use nurses as a resource in any effort to integrate CAM into conventional medicine. Nurses can serve as a bridge to help educate doctors. (**Charlotte Eliopoulos, American Holistic Nurses Association, AHNA**)

- Create access to CAM therapies that are considered to be safe. However, embrace reimbursement only for those therapies that have strong evidence supporting their effectiveness.(**James Dillard, M.D., Oxford Health Plans**)

- Continue to support scientific investigations into CAM treatments to help separate what is effective from what is not. (**Anna Silberman, High Mark Blue Cross/Blue Shield**)

- Promote proven CAM interventions to the public. (**Anna Silberman, High Mark**)

- Influence health plans to reimburse for evidence-based CAM interventions. (**Anna Silberman, High Mark**)

- Determine what are the most common guidelines for setting limits for access and apply them to CAM. Otherwise, carriers could be allowed to sell what is essentially an illusory benefit. (**Lori L. Bielinski, Washington State Office of the Insurance Commissioner**)

- Reimburse for Vedic medicine services that are shown to be effective and cost-effective in published, peer-reviewed scientific research, should be reimbursed,

including by government payers, such as Medicare and Medicaid, and private reimbursers. (**Robert Schneider, M.D., Marharishi University**)

- Allow certified Vedic practitioners should be allowed to practice in their areas, following the Minnesota model. States should adopt a licensure procedure for natural medicine practitioners, including Vedic medicine practitioners, and licensure would be dependent on certification and completion of other state licensing requirements, such as an exam or experience requirements. (**Robert Schneider, M.D., Marharishi University**)

- Federal grant should be made to educational institutions of higher learning for the training of Vedic medicine practitioners. (**Robert Schneider, M.D., Marharishi University**)

- Develop a system of integrative medicine in which a cadre of health care disciplines and practitioners, each with their own scope of practice, their own tools of their trade, but with a common understanding, common respect, and a shared commitment can coordinate care, cross-refer, and co-manage patients. (**Tori Hudson, N.D., National College of Naturopathic Medicine**)

- Change the current reimbursement model, which favors the delivery of the modality over the healing art of the individual patient. (**Robert Duggan, President of the Traditional Acupuncture Institute, TAI**)

- Encourage schools of medicine, complementary and mainstream, to foster relationship-centered care. (**Robert Duggan, TAI**)

- Establish a separate agency, other than the FDA, to deal with the issue of the quality of herbs. (**Robert Duggan, TAI**)

- Support a bill currently before Congress that would forgive student loans to induce CAM practitioners who work in impoverished areas. (**Robert Duggan, TAI**)

- Establish initiatives to foster CAM and wellness education from the first grade onward. (**Robert Duggan, TAI**)

Panel 5: CAM Integration into Existing Delivery Systems

- Break down the barriers to collaboration with CAM practitioners as well as the barriers to reimbursement for CAM services. (**Milton Hammerly, M.D., of Catholic Health Initiatives, CHI**)

- Pay more research attention to the interface of the issues of spirit and the neurophysiology of craving and compulsion and reward. (**Alan Trachtenberg,**

M.D., Office of Pharmacologic and Alternative Therapies at the Center for Substance Abuse Treatment, CSAT)

Public Comment:

- Provide major medical schools and research centers throughout the United States with funding to set up models to study various CAM therapies, such as herbal medicine, homeopathy, and acupuncture. (**Nancy Dolores Kolenda, Director of the Center for Frontier Sciences at Temple University**)

- Establishment an emergency, "crash" educ ation program on CAM for: 1) the approximately one-half million practicing physicians, 2) academic research scientists, and 3) the general attentive public. (**Rustrum Roy, University of Arizona Program for Integrative Medicine**)

- Place a major focus on wellness and to recommend policies for reimbursing CAM providers for health promotion. (**Bruce Nordstrom, American Chiropractic Association**)

- Promote initiatives to integrate nutrition into the core curricula at American medical schools, encourage the Public Health Service issue grants for research on the effects of vegetarian and vean diets for a number of chronic illnesses, and encourage the Department of Agriculture review of federal policies that conflict

with healthy nutritional goals. (**Neal Barnard, President the Physician's Commission for Responsible Medicine**)

- Promote reimbursement of services rendered by Oriental Medicine physicians by all health insurance providers, both Federal and private. (**Doreen Chen, American Association of Oriental Medicine**)

- The development of a 20-year plan to integrate conventional medicine into patient-centered, whole-person health care. (**Gary Sandman, founder of a community-based alternative medicine referral service**)

- Promote the incorporation of new codes into Federally funded CAM research so that cost-effective CAM treatments can be identified as a solution to escalating health care expenses, especially where these procedures could have an impact on Medicare/Medicaid recipients. (**Melinna Giannini, Director of Alternative Link**)

- Require the National Institutes of Health and the Department of Agriculture to conduct new research on the efficacy of diets that seek to reduce or treat many behavioral, learning, and health problems in children by eliminating synthetic dyes, artificial flavors, and certain preservatives from their diet. (**Jane Hersey, Director of the Feingold Association**)

- Support research on the role of toxic chemicals in syndromes, such as multiple chemical sensitivities, auto-immune diseases, fibromyalgia syndrome, and chronic fatigue syndrome. There also is the need for research to investigate the role of nutritional supplements in enhancing improved metabolic function in these syndromes. (**Lawrence A. Plumlee, M.D., National Coalition for the Chemically Injured**)

- Promote programs to educate medical students and physicians about the use and effectiveness of all CAM modalities, especially medical acupuncture, and teach them that CAM is not a threat to their practice. (**Marshall Sager, President-elect of the American Academy of Medical Acupuncture**)

Categories of Recommendations

(1) Availability, Access, + Delivery (Jan)

(2) Education + Training Jan

(3) Information Development + Dissemination Comm

(4) Licensing, ~~Credentialing~~ Credentialing, + Certification (Jan)

(5) Reimbursement - Maureen

(6) Research - Geri

(7) Selfcare - Comm

(8) Wellness - Comm

Coordination with Executive Order:

		Category
A)	Research to Increase Knowledge:	6
B)	Provision of Reliable + Useful Information:	3, 8, 7?
C)	Appropriate Access + Delivery	1, 5, 7?
D)	Education and Training	2, 4

My name is Corinne Giantonio PhD and for 20 years I have worked as a Psychologist for Kaiser Permanente. In the past 7 yr. I participated in the Development of a Health Plan Wide Program to provide Comprehensive and Integrated Care merging multiple alternative medicine treatments with traditional medicine, made available to all Health Plan Members covered by the basic insurance plan. For three years, I worked in the front line in Primary Care Medicine interfacing daily, directly and full time with patients, Physicians, Nursing staff, Yoga and Meditation Masters, Acupunturists, Psychiatry staff, Nutritionists, Exercise physiologists and Physical therapists as this Comprehensive Care program was implemented. I'd like to summarize for the Commission some of the major findings and some of the major obstacles faced as this effort at integrating Alternative Medicine Options with Primary Care Delivery of Services.

Four Main Interest Groups arose in the Administration of this Integrated Care Program

- **Patients**
- **Physicians—Primary Care and Specialty Medicine**
- **Alternative Medicine Specialists and Professionals**
- **The Insurance Plan**

Understanding the demographics of each of these interest groups is essential to any efforts the Commission for Alternative Medicine may make in achieving its Mission of generating a Consortium of Recommendations aimed at making alternative medicine modalities available to the Public. I'd like to highlight some of the results of our many formal studies over those seven years.

The Patient

- The educated, motivated patient will seek out alternative medicines and will generally have the financial resources to seek out Fee for Service options:
    - Yoga retreats, Meditation Groups, Massage Therapy, Aroma Therapy, Mind/Body Medicine Series and various noetic sciences NOT the population presenting itself to the insurance Dollar
- Most dramatically benefitting: Chronic Pain Patients (Pain persisting 3-6 months following trauma) Chronic Illness Sufferers: **38%-79% decrease in medical visits over period of two years following intervention of Integrated Medicine**
    - Muscular-Skeletal: e.g. Fibromyalgia
    - Arthritis
    - Digestive disorder: IBS chronic Nausea, diarrhea
    - Cardiovascular: Chest pain, High Blood Pressure, High Cholesterol, Heart Palpitations
    - Pulmonary: Shortness of Breath
    - Neurological: Headaches, dizziness, lightheadedness
    - Fatigue
    - Sleep Disorders
- Demographics of this under-served Population Presenting itself to Primary Care (Insurance Covered Option)
    - Uninformed re the nature and parameters of Chronic Illness in General
    - Unrealistic Expectations of Prognoses
    - Generally passive vs. active in his/her own participation in wellness practices
    - Life style usually one of excess:Physical Overextension, or Extreme Withdrawal vs. Pacing
    - High incident **(62-76%) co-morbidity with psychological distress: Anxiety and/or Depressio**

- The "Worried Well", Stress-induced symptoms
- The Stable Elderly
- High incidence (90-98%)of Anger, Frustration, Distrust in the competency of Practitioners in Traditional Roles, Distrust in the competency of Practitioners in non Traditional roles

The Physician

- Predominant attitudes:
  - Helplessness: " I have nothing to offer this patient"
  - Powerlessness: " Limitations of traditional options: pharmaceuticals, surgery
  - Distrust: of the competency of practitioners in non-traditional medicine
  - Reluctance to refer to practitioners in non-traditional roles
    - Lack of education and information re the medical benefits **(78%)**
    - Perception of "relinquishment of the primary medical management of the patient when referring to non-traditional alternatives **(89%)**
    - Sense of "abandonment" when option of referral **(86%)**
    - Concern about the discontinuity between primary traditional management and the alternative medicine treatment intervention **(91%)**
- Resistance at considering the psychological and behavioral aspects of the presenting symptoms at first assessment **(self-reported perception – 24%) (as rated by independent assessment of initial MD eval – (98%)**
- Reluctance to approach treatment plan as a partnership with the patient **(self-reported 16%) (as rated by independent audit – 94%)**
- Designated (too many obstacles to getting pt. into alternative medicine option" as number 1 or 2 for reasons for NOT referring **(87%)**

The Alternative Medicine Practitioner:

- Characteristics of Professions regarded as "having established credibility" and most utilized as referral option:
  - Had licensure in place **(89%)**
  - Regulated own profession to point of med/legal censureship **(38%)**
  - Education Requirements: pre and post clearly articulated **(63%)**
  - Clear Proficiency exams **(89%)**
  - Able to generate specific symptom-reduction outcome studies that were measureable and repeatable and behavioral in nature **(76%)**
- Behavioral Characteristics of successful Alternative Medicine Practitioners
  - Able to provide clear written referral procedures **(63%)**
  - Referral procedures reflected the "Overall Treatment Plan" remained in the hands of the Primary Care MD **(76%)**
  - Alternative Medicine Treatment Plan was symptom specific in assessment language and behavioral specific in treatment recommendation and outcome goals **(89%)**
  - Patient was returned to the Primary Care Physician with Behavioral Outcomes and treatment plan for self-management clearly articulated. **(56%)**
  - Treatment plan was time-limited **(82%)**
  - Found and identified patient within traditional medicine's purvue

- Conducted ongoing educational or grand round presentations to Primary Care **(66%)**
- Conducted ongoing educational opportunities for Chronic Pt. Population **(73%)**
- Demonstrated behaviorally measureable success with the "unmotivated, reluctant pt. population
- Available to Physician for consult and co-evaluation **(36%)**
- Demonstrated competence in either screening or assessing of co-morbid psychological overlays, specifically anxiety and depression disorders. **(43%)**

The Insurance Company:

- Covered benefits reflect adage that Illness rather than Health Care consumes the Insurance Dollar, Primary Budget reflects no <10% commitment to alternative Medicine Options
- Upstream, preventive intervention by way of patient education and motivational intervention will leverage the insurance dollar with greatest impact
- Fund research in alternative medicine that reflects evidence-based reduction in medical visits
- Seek government incentives for sponsoring such research

Challenges to the Commission for Alternative Medicine

Consider **all players** in consortium and collaboration: **Patient, Physician/Insurance, Alt.Med Practitioner** when making its recommendations

- The patient spectrum
  - Educated and motivated **(8-12% of the population)**
  - Uneducated, Unmotivated, **(90% of the population)**
  - Victims of Chronic Illness
  - Suffering from co-morbidity with anxiety/depression **(62-76%)**

- The existing medical structure: **The Physician, Insurance Industry** (Fee for Service, Medicare, Medicaid, HMO)
  - Primary Care responsible for overall Care Plan
  - PCP (Primary Care Physician) in need of education and research data
  - PCP most likely to overcome territorial issues when treatment options approached as Partnership with Pt. (Pt assumes co-responsibility for Tx Plan)
  - The role Fee for Service vs Insurance Covered Benefit for the Motivated, Educated pt. vs the Uninformed, unmotivated pt. suffering from Chronic Illness

- **The Alternative Medicine Practitioner**
  - Assumes Responsibility for the Integrity of its respective Profession:
    - Monitors itself with clearly stated educational requirements, proficiency exams, and legal censureship
  - Demonstrated ability to liason with traditional Medicine: Physicians and Insurance
  - Can generate cooperative treatment plans that are **behavioral** and **measureable** in nature and produce outcome goals that are **behavioral and measureable.**

INTEGRATIVE MEDICINE

Physician Resources

Leonard A. Wisneski, M.D.

3/99

I. Books

1. General

Rudolph Ballantine, M.D., "Radical Healing"

Adriane Fugh-Berman, M.D., "Alternative Medicine: What Works"

Barrie R. Cassileth,Ph.D., "The Alternative Medicine Handbook"

William Collinge, M.P.H., Ph.D., "Alternative Medicine"

Elliott S. Dacher, M.D., "Whole Healing"

Edzard Ernst, M.D., Ph.D., "Complementary Medicine: An Objective Appraisal"

Ralph Golan, M.D., "Optimal Wellness"

James S. Gordon, M.D., "Manifesto for a New Medicine"

Rena J. Gordon, Ph.D., "Alternative Therapies: Expanding Options in Health Care"

Ronald L. Hoffman, M.D., "Intelligent Medicine"

Jennifer Jacobs, "Encyclopedia of Alternative Medicine"

Tanvir Jamil, BSc., BM, MRCGP, "Complementary Medicine: A Practical Guide"

Kathi J. Kemper, M.D., "The Holistic Pediatrician"

Skye Lininger, "The Natural Pharmacy"

Marc S. Micozzi, M.D., Ph.D., "Fundamentals of Complementary and Alternative Medicine"
"The Physician's Guide to Alternative Medicine"

Ralph W. Moss, Ph.D., "Alternative Medicine Online"

Michael Murray, N.D., "Encyclopedia of Natural Medicine"

Gary Null, Ph.D., "The Clinician's Handbook of Natural Healing"

Andrea Peirce, "The American Pharmaceutical Association: Practical Guide to Natural Medicines"

Joseph E. Pizzorno, N.D., "A Textbook of Natural Medicine"

Isadore Rosenfeld, M.D., "Dr. Rosenfeld's Guide to Alternative Medicine"

Stephen T. Sinatra, M.D., "Optimum Health"

John W. Spencer, Ph.D., & Joseph J. Jacobs, M.D., "Complementary/Alternative Medicine: An Evidence Based Approach"

Marcellus Walker, M.D., "The Physician's Guide: Natural Health for African Americans"

Andrew Weil, M.D., "Spontaneous Healing"
"Roots of Healing: The New Medicine"

2. Nutrition

Michael Murray, N.D., "Encyclopedia of Nutritional Supplements"

Dean Ornish, M.D., "Love and Survival"

Melvyn Werbach, M.D., "Healing Through Nutrition"
"Nutritional Influences on Illness"

3. Herbal Medicine

Mark Blumenthal, "The Complete German Commission E Monographs"

James A. Duke, Ph.D., "The Green Pharmacy"

Daniel Mowrey, Ph.D., "The Scientific Validation of Herbal Medicine"

Michael Murray, N.D., "The Healing Power of Herbs"

PDR for Herbal Medicines

Varro Tyler, Ph.D., "The Honest Herbal"

4. Functional Medicine

Sidney M. Baker, M.D., "Detoxification and Healing"

Jeffrey Bland, Ph.D., "The 20 Day Rejuvenation Program"

Leo Galland, M.D., "Power Healing" (The Four Pillars of Healing)

5. Homeopathy

Bob Leckridge, BSc, MB, ChB, MFHom, "Homeopathy in Primary Care"

Wayne B. Jonas, M.D., "Healing with Homeopathy"

6. Mind-Body (PNI)

Herbert Benson, M.D., "The Wellness Book"

Daniel Goleman, M.D., "Mind-Body Medicine"

Jon Kabat-Zinn, Ph.D., "Full Catastrophe Living"

7. Chinese Medicine

Daniel Reid, "The Complete Book of Chinese Health and Healing"

Gabriel Stux, M.D., "Basics of Acupuncture"

8. Ayurveda

Hari Sharma, M.D., FRCPC, "Contemporary Ayurveda"

David Simon, M.D., "The Wisdom of Healing"

9. Bodywork

Eyal Lederman, "Fundamentals of Manual Therapy"

Mirka Knaster, "Discovering the Body's Wisdom"

10. Specific Disorders

Jacob Teitelbaum, M.D., "From Fatigued to Fantastic"

II. Journals

Advances: The Journal of Mind-Body Health
John E. Fetzer Institute, Kalamazoo, MI
616-375-2000

Alternative & Complementary Therapies
Mary Ann Liebert, Inc., 2 Madison Avenue, Larchmont, N.Y. 10538
914-834-3100 or 800-M-LIEBERT or FAX 914-834-1388
email: info@liebertpub.com

Alternative Therapies in Health and Medicine
InnoVision Communications, 101 Columbia, Aliso Viejo, CAQ 92656
800-899-1712 or FAX 949-362-2049
www.alternative-therapies.com

American Journal of Clinical Nutrition
9650 Rockville Pike, Bethesda, Md. 20814-3998
FAX 301-571-8303 www.faseb.org/ajcn

Brain, Behavior and Immunity
Academic Press, San Diego, CA 619-230-1840

British Medical Journal
BMJ Publishing Group, P. O. Box 590A, Kennebunkport, ME 04046
1-800-2-FON-BMJ or FAX 1-800-2-FAX-BMJ
email: bjpaige@cybertours.com

Common Boundary
P.O.Box 445, Mt. Morris, IL 6105407819
800-548-8737 or 815-734-1117
www.commonboundary.org

International Journal of Integrative Medicine
IMPAKT Communications, PO Box 12496, Green Bay, WI 54307-2496
1-800-477-2995
www.impakt.com

Lancet
P.O.Box 7427, Philadelphia, PA 19101-8974
800-462-6198 or FAX 212-633-3850
www.thelancet.com

Journal of Alternative and Complementary Medicine
Mary Ann Liebert, Inc., 2 Madison Avenue, Larchmont, N.Y. 10538
914-834-3100 or 800-M-LIEBERT or FAX 914-834-1388
email: info@liebertpub.com

Journal of the American College of Nutrition
American College of Nutrition c/o Hospital for Joint Diseases
301 East 17 Street, New York, New York 10003
212-777-1037 or FAX 212-777-1103

Journal of Holistic Nursing
Sage Publications, Inc., 2455 Teller Road, Thousand Oaks, CA 91320
805-499-0721 or FAX 805-499-0871
www.sagepub.com

Natural Medicine
Fairfax Publications, Inc., 828 High Ridge Road, 2nd Floor, Stamford, CT 06905
203-595-0006 or FAX 203-322-5544 or email: NMEDJRNL@aol.com

New England Journal of Medicine
NEJM Customer Service Dept, PO Box 803, Waltham, MA 02454-0803
1-800-THE-NEJM or www.nejm.org

Nutrition Reviews
Subscription Office, PO Box 1897, Lawrence, KS 66044-8897
785-843-1235 or FAX 785-843-1274

Science News
PO Box 1925, Marion, Ohio 43305
1-800-552-4412

Spirituality & Health, The Soul/Body Connection
74 Trinity Place, New York, New York 10006
212-602-0705 or FAX 212-602-0726
www.spiritualityhealth.com

Townsend Letter
911 Tyler Street, Pt. Townsend, WAS 98368-6541
360-385-6021 or FAX 360-385-0699
www.tldp.com

III. Newsletters

Alternative Medicine Alert
American Health Consultants, PO Box 740056, Atlanta, GA 30374
1-800-688-2421 www.ahcpub.com

Clinical Pearls News (Current Research in Nutrition & Preventive Medicine)
IT Services, 3301 Alta Arden, #2, Sacramento, CA 95825
916-483-1085 or FAX 916-483-1431

Complementary & Alternative Medicine at the NIH
PO Box 8218, Silver Spring, Md 20907-8218
888-644-6226 or FAX 301-495-4957
http://altmed.od.nih.gov

Complementary Medicine for the Physician
W.B. Saunders Co., 6277 Sea Harbour Dr, Orlando, FL 32821-9816
1-800-654-2452

Health Alert (Dr. Bruce West)
5 Harris Court, N6, Monterey, CA 93940
831-372-2103

Homeopathy Today
National Center for Homeopathy, 801 North Fairfax St., #306, Alexandria, VA 22314
703-548-7790 or FAX 703-548-7792
www.homeopathic.org

Integrative Medicine Consult
1029 Chestnut St., Newton, MA 02464
617-641-2300 or www.onemedicine.com

Environmental Nutrition
PO Box 42051, Palm Coast, FL 32142-0451
1-800-829-5384

Herbalgram
American Botanical Council, PO Box 201660, Austin, TX 78720-1660
800-373-7105 www.herbalgram.org/abcmission.html

Lawrence Review of Natural Products
Facts and Comparisons, 111 West Port Plaza, #400, St. Louis, MO 63146-3098
314-878-2515 or 800-223-0554

Mind-Body Medicine
Decker Periodicals, Hamilton, Ontario
800-568-7281

Nutrition & the M.D. (University of California)
Lippincott Williams & Wilkins, 12107 Insurance Way, Hagerstown, Md. 21740
800-777-2295 or www.lww.com

Practical Reviews – Complementary & Alternative Medicine
Oakstone Medical Publishing, 6801 Cahaba Valley Road, Birmingham, AL 35242
1-800-633-4743 or www.edreview.com

Self Healing (Dr. Andrew Weil)
Thorne Communications, Inc., 42 Pleasant St., Watertown, MA 02472
1-800-523-3296

Tufts Health and Nutrition Letter
53 Park Place, 8th Floor, New York, NY 10007
800-274-7581 http://healthletter.tufts.edu

Wellness Letter (University of California, Berkeley)
PO Box 420148, Palm Coast, FL 32142
904-445-6414

IV. Electronic Media

Integrative BodyMind Information System (IBIS 99)
Integrative Medical Arts Group, Inc.,
4790 SW Watson Avenue, Beaverton, Oregon 97005
503-641-6419
www.integrativemedicalarts.com

Alt – Health Watch
Softline Information
1-800-524-7922

Health Notes Online
Virtual Health, LLC
1125 SE Madison, Suite 209, Portland, Oregon 97214
www.healthnotes.com Email: info@healthnotes.com FAX 1-503-234-4052

Essentials of Functional Medicine
The Institute for Functional Medicine
HealthComm International, Inc.
5800 Soundview Drive, Gig Harbor, Washington 98335
1-800-843-9660: FAX 253-851-9749

Gift of Homeopathy
KHA International 415-457-0578
Email: kha@igc.org www.kenthomeopathic.com

Nutritional Influences on Illness
Third Line Press, Inc.
4751 Viviana Drive, Suite 500, Tarzana, CA 91356
1-800-916-0076 or 818-996-0076; Fax 818-774-1575
www.third-line.com E-mail: tlp@third-line.com

The Herbalist
Hopkins Technology
David Hoffman, Hopkins, MN 55343-7116
612-931-9376

Homeopathy Resource
Chiltern Hills Wellness
P. O. Box 300, Willernie, MN 55090-0300
FAX 651-426-3258
E-mail: sales@chilternhillswellness.com
www.chilternhillswellness.com

Traditional Chinese Medicine and Pharmacology
Hopkins Technology
Hopkins, MN 55343-7116
612-931-9376

V. Websites

Cochrane Library
www.update-software/com/ccweb/cochrane/revabstr/ccabout.htm#other

American Holistic Medical Association
www.holisticmedicine.org/

Alternative Health News Online
www.altmedicine.com

Alternative Medicine Connection
arxc.com/arxchome.htm

Alternative Medicine Links
www.altmedicine.com/app/registeruser.cfm

Alternative Therapies in Health and Medicine
www.alternative-therapies.com

Alternative Medicine.com
www.alternativemedicine.com

American Academy of Medical Acupuncture
www.medicalacupuncture.org

American Botanical Council
www.herbalgram.org

American College for Advancement in Medicine
www.acam.org/index.html

Aries Systems Corporation
www.kfinder.com/newweb

Botanical Medicine Resources on the Web
cpmcnet.columbia.edu/dept/rosenthal/botanicals.html

CNN – Health
www.cnn.com/health

Complementary and Alternative Medicine Research
www-camra.vcdavis.edu

Dr. Bower's Complementary Medicine Home Page
galen.med.virginia.edu/~pjb3s/complementaryhomepage

Dr. Weil - Ask a Question
cgi.pathfinder.com/drweil/sitemap

Health Care Information Resources – Alternative Medicine
www-hs/.mcmaster.ca/tomflem/altmed.html

Health A to Z: The Source for Health and Medicine
www.healthatoz.com

HealthWorld Online
healthy.net

Health WWWeb Choices for Health
www.healthwwweb.com/home.html

Herb Research Foundation
www.herbs.org

Holistic Internet Resources Homepage
www.hir.com

Integrative Medical Arts Group
www.integrativemedicalarts.com

The Australian Alternative Health Directory
www.aahd.com.av/index.htm

MD Consult Clinical Information for Physicians
www.mdconsult.com

Natural Health Village
www.naturalhealthvillage.com

One Medicine
www.onemedicine.com

Physicians' Online
www.po.com

Reuters Health Information
www.reutershealth.com

Rosenthal Center
cpmcnet.columbia.edu/dept/rosenthal

The Alternative Medicine Homepage
www.pitt.edu/~cbw/altm.html

Tufts University Nutrition Navigator
navigator.tufts.edu

National Library of Medicine
www.n/m.nih.gov

Altmednet.com
www.altmednet.com

PubMed
www.ncbi.nlm.nih.gov/PubMed

Yahoo Health – Alternative Medicine
www.yahoo.com/health/alterntive_medicine/index.html

Your Health Daily – NYT Syndicate
yourhealthdaily.com

America Online
"Health" Channel, then "Healthy Living", then "Alternative and Complementary Medicine"

VI. Organizations

American Academy of Medical Acupuncture
5820 Wilshire Blvd, #500, Los Angeles, CA 90036
213-937-5514; FAX 213-937-0959

American Association of Naturopathic Physicians
601 Valley St., #105, Seattle, WA 98109-4229
206-298-0126; FAX 206-298-0129
www.infinite.org/Naturopathic.Physician

American Botanical Council
BOX 201660, Austin, TX 78720-1660
512-331-8868; FAX 512-331-1924
www.herbalgram.org

American Holistic Medical Association
6728 Old McLean Village Dr., McLean, VA 22101
703-556-9245; FAX 730-556-9728

Herb Research Foundation
1007 Pearl St., #200, Boulder, CO 80302
800-748-2617 or 303-449-2265; FAX 303-449-7849
www.herbs.org/

International Society for the Study of Subtle Energies and Energy Medicine (ISSSEEM)
356 Goldco Circle, Golden, CO 80403
303-425-4625; FAX 303-425-4685
http://vitalenergy.com/issseem

Office of Alternative Medicine
PO Box 8218
Silver Spring, MD 20907-8218
888-644-6226; FAX 301-495-4957
http://altmed.od.nih.gov/oam/

White House Commission on

Complementary and Alternative Medicine Policy

Town Hall Meeting: January 23, 2001,

New York, New York

Commissioners in Attendance:

James Gordon, David Bresler, Effic Chow, George DeVries, Joseph Fins, Veronica Guitierrez, Charlotte Kerr, Linnea Larson, Conchita Paz, and Xiaoming Tian

Special Invited Guests: Gilberto Cardona, M.D., Acting Regional Director, Department of Health and Human Services, Region II

Introduction:

On Janurary 23rd, 2001, the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) held a town hall meeting at the Lighthouse International Conference Center, Ames Autorium, 111 E. 59th Street, in New York City. The WHCCAMP heard testimony from 22 separate panels, which more than 130 individuals representing professional and consumer groups, individual physicians and CAM practitioners, representatives from major medical centers and small community-based clinics offering CAM services, and individual patients.

The following is a summary of testimony presented by panels as well as specific recommendations made in a number of specific areas. A complete list of speakers and their panel assignments is included at the end of this document. A complete transcript of the testimony given at this Town Hall meeting can be downloaded from the WHCCAMP web site at (give URL here.)

Panel 1: CAM Regulation

In Panel I, the Commissioners heard testimony from: 1) two New York State regulatory officials officials said that it was their responsibility to protect the public from medical negligence or unethical or illegal practices by healthcare providers, both conventional and CAM., 2) two attorneys who have defended CAM practitioners in court against state regulatory actions who said state schemes that are set up to regulate physicians have a discriminatory impact upon CAM physicians, mainly because the regulatory staffs do not have an adequate understanding of CAM treatment modalities, 3) a CAM consumer who said she believes that most CAM therapies achieve their results without harm and without leaving chemical residues in the body or using invasive techniques, and 4) a representative of a CAM professional organization who said there is already a significant body of published peer reviewed research that clearly demonstrates that mental, emotional, and spiritual factors significantly affect a person's health and well-being.

Specific Recommendations:

1. The Commission should not advocate the spread of the traditional regulatory model for CAM services and should refrain from applying uniform standards of education, training, or licensure to all CAM practitioners.
2. The literature on mind-body approaches to health and well-being needs to be collated and reviewed by an independent panel and then an emphasis be placed on educating health care professionals and the public about what is already known.

Panel 2: Consumer Access to CAM and CAM information

In Panel 2, the Commissioners heard testimony from: 1) the president of a public policy research organization that consumer access to CAM is often blocked by either financial obstacles or by a lack of information about the full range of treatments available, 2) a chronic disease patient who elucidated five issues that the Commission should address (see transcript), 3) a psychiatrist who heads a CAM health center said single largest source of waste in American health care today has been the neglect of teaching consumers CAM self-healing and health promotion, such as stress reduction and meditative practices, which have been scientifically proven by over 50 years of research, 4) a CAM researcher, and 5) the president of an integrative medicine foundation who said that medical students need to learn about CAM modalities from the perspective of restoring harmony and balance, not just about treating disease.

Specific Recommendations:

1. The commission should investigate changes in tax policy that would lead to greater access to CAM. This would allow people would be able to choose for

themselves, instead of having bureaucracies decide what treatments are and are not covered.

2. The establishment of more CAM research centers and funding to encourage more scientists to become specialists in CAM research and educate current and the future scientists and medical practitioners about various CAM therapies.

3. People who have multiple chronic conditions and who are routinely rejected for standard clinical trials be especially targeted for CAM clinical trials.

Panel 3: CAM and Women's Health

Panel 3 included: 1) the director of an NIH-funded CAM research center that focuses on women's health who said there is a need for studying systems of medicine for treating women's health problems, not just randomized controlled trials of individual therapies, 2) an acupuncturist and Chinese herbal medicine practitioner who said there needs to be better medical education about CAM as well as a large cadre of people with an understanding of CAM involved in its research., 3) two breast cancer survivors who said CAM therapies had played a large role in helping them survive their illnesses and that that patients should have the right to receive treatment that has been proved successful for their conditions , 4) an integrative medicine practitioner who treats womens' health problems who said if doctors are to become educators and teachers of prevention and self-care to their patients, then they need to embody those teachings themselves, and 5) the director of a wholistic health center that treats many women with breast cancer who said that the U.S. is far behind many European countries in integrating CAM modalities to enhance conventional othologic care for cancer.

Specific Recommendations:

1. Clinical research studies involving high dose chemotherapy on human participants should not be allowed unless there is supportive pre- and after-care CAM services, such as acupuncture and massage, provided.
2. Promote programs to teach self-awareness techniques (e.g., yoga) to doctors as part of a mandatory training program on CAM.
3. Require medical schools teach in-depth courses in the fundamental principles of Oriental medicine.
4. Require the government promote insurance reimbursement for CAM therapies so that many patients can afford to have these therapies.

Panel 4: CAM Research and Information

In Panel 4, commissioners heard from: 1) founder of a CAM education organization who said that almost 90 percent of cancer patients are interested CAM but rarely discuss the issues with their doctors, 2) the friend of a cancer survivor who her friend had to go to Mexico to get live-saving CAM therapies, which were not approved in the U.S. nor reimbursed by insurance., 3) the director of an Oriental medicine society said that quality standards of care are best developed and assured through high standards of education and examination, and 4) a representative of an osteopathic college who said that the collection of case studies from all CAM practitioners is a national imperative.

Specific Recommendations:

1. Promote funding for CAM therapies that both fight cancer as well as reduce the toxic side effects of chemotherapies.
2. the development of a national database system that would permit physicians utilizing an electronic version of an soap note, to collect their data on patient care and input it into this soap note data base.

Panel 5: Physician Practice of CAM in New York State

In Panel 5, Commissioners heard from: 1) three physicians under investigated for medical misconduct by the New York State Officials who said their rights have been violated by the State of New York, which has tried to take away their medical licenses and put them out of business, and 2) a representative of a consumer's health organization who said although New York State has a law stating that doctors should not lose their license just because they practice nonconventional therapies, are being prosecuted nonetheless.

Specific Recommedations:

1. State regulators of CAM therapies should be bound by the rules of evidence and their jurisdiction be limited to cases of irreparable patient harm.

Panel 6: CAM and Sports Medicine

In Panel 6, the Commissioners head from: 1) a reflexology practitioner who said that her discipline is not massage and should not be regulated as such, 2) a satisfied CAM consumer there need to be more programs to promote awareness of these specialties and affordable access, which would enhance the well-being of all, 3) a representative of a

CAM-advocacy who said he is working to reform the state agency in New York that regulates CAM and is promoting a campaign for patients rights , 4) two former Olympic athletes and trainers who said aid that top athletic performers offer HMOs and insurance companies a unique group of people to study in terms of the efficacy of various healing art forms, and 6) an internist and sports medicine expert.who said the cascading problems of performance enhancing drugs and dietary supplements in sports is a crisis. Of particular concern, he said, are the estrogen and testosterone precursors, which can significantly increase cancer risks.

Specific Recommendations:

1. Allow CAM practitioners to govern themselves as long as they provide full disclosure of their pertinent information to their clients/consumers.
2. The establishment of a Center to gather and synthesize existing information on how to promote mind-body wellness in youths, competitive athletes, and older people in sport and in physical and cultural arts.
3. Coordinate research on the health data that has been collected on athletes over the past 20 years as well as to coordinate future research with sports organizations.
4. Support Senate Bill 1159, which provides grants and contracts to local educational agencies to initiate, expand, and improve physical education programs for all kindergarten through 12th grade students.
5. Work to change the Dietary Supplement Health Education Act of 1994 by explicitly remove steroid-based supplements from the list of protected CAM therapies.

Panel 7: Pediatric Patients and CAM

In Panel 7, Commissioners heard testimony from: 1) a mother who has administered CAM to her children and said such therapies have been extremely beneficial, 2) a journalist and parent of a young man with special needs who said he and his family have t0 deal with pediatricians and medical specialists, who, for the most part, know little about human development, 3) the mother of a boy who was diagnosed with attention deficit hyperactivity disorder (ADHD) said he was treated with a homeopathic remedy with dramatic improvements, 4) the father of a boy Canavan disease, a fatal neurological genetic disorder, who said that the FDA has been the biggest obstacle in his ability to get effective treatments for his son, and 5) the father of a terminally ill five-year-old with medulloblastoma and a filmmaker making a documentary about the boy, who said before we can embrace new types of medicine, we must first recapture our freedom from regulatory agencies:

Specific Recommendations:

1. Provide more oversight of FDA.
2. Require FDA to have more contact with patients and consumer groups in making decisions about the availablity of therapies, particularly for life-threatening conditions.

Panel 8: CAM Integration and Information

In Panel 8, the commission heard from: 1) a representative of an integrated medical clinic who said that ensuring equal access to CAM for all citizens should be of the highest priority for health care reform., 2) a CAM-practicing family doctor who said that CAM education is critical to the education of health care professionals, 3) the director of the graduate program in Oriental Medicine who said the chief barrier CAM integration is the general lack of in-depth education on CAM among all healthcare, 4) a pediatric psychologist who works with critically ill children who said that CAM approaches are child friendly and need to be made more widely available to pediatric patients, and 5) the education director of a CAM research center who said CAM practitioners need help in doing case reporting and that there is an incredible amount of important clinical information that gets lost because there is not a easy mechanism for case reporting.

Specific Recommendation:

1. Provide people without health insurance or inadequate coverage equal access to CAM therapies.
2. Make CAM education a required, not elective, part of health care professionals curriculum.
3. Enhance federal support for acupuncture and oriental medicine education and other discipline specific education; hospital-based residencies in other forms of medicine; research aimed at providing answers and innovative means of asking questions that are discipline specific; educational infrastructure of all other forms of medicine; and opening up Medicare and Medicaid reimbursement to acupuncture and oriental medicine, and other forms of medicine.

4. Increase qualifications for pediatric practitioners to include better understanding of traditional, naturopathic, and oriental approaches for pediatric conditions; provide better educational information for both parents and pediatricians alike to improve informed consent on behalf of children for CAM and traditional therapies.
5. Develop better mechanisms for case reporting so that patients and physicians facing difficult cases could search for similar cases in the literature.

Panel 9: CAM Education for Health Providers

In Panel 9, the Commissioners heard from: 1) the representative of a holistic medicine association who said it critical for physicians to be well trained in CAM , 2) a representative of holistic nurse association who said that many nurses want to heal the body, mind, and spirit with integrity and freedom and need more information on how to do so, 3) a representative of a public health association who said that the physicians need a much more extensive exposure to CAM then they currently receive, 4) the founder of a CAM institute who said patients being treated with natural medical techniques by conventional medical professionals are most likely not getting the best traditional care, and 4) a naturopathic physician who said the effort to subsume naturopaths into conventional medicine and current medical regulation should be stopped.

Specific Recommendations:

1. Integrate the teaching of CAM into the entire medical school curriculum; provide CAM education in clinical relevant enviroment so students can see how it is practiced in the field.

2. Increase funding to aid and promote education in college courses about CAM and make it easier for private-practice nursing CAM practitioners to promote and participate in CAM practice models for research.
3. Develop better sources of information on CAM for medical professionals on legal, research, regulatory, insurance reimbursement, and educational issues;
4. Require extensive training in CAM for those who oversee CAM research and education programs.
5. Create an environment of diversity and freedom in health care; create greater understanding of concept of holism for conventional medical physicians and patients.
6. Promote official recognition of the difference between naturopathy and Naturopathic physicians. Naturopaths are non-medical, whereas naturopathic physicians are and should study medicine before studying naturopathy. Different board certifications for naturopaths and naturopathic physicians.

Panel 10: Naturopathic Medicine

In Panel 10, the Commissioners heard from: 1) a representative of a naturopathic physicians association who said for conventional medicine to understand the value of naturopathic medicine, allopathic basic and clinical medical science curricula need to be reworked to include these philosophical elements, 2) an emergency medicine physician who teaches medicine at a naturopathic college who said there is really no naturopathic counterpart in allopathic medical schools who can teach physicians about natural or naturopathic medicine, 3) a student at naturopathic medicine college who said

naturopathic medicine is at the forefront of the CAM health care movement, 4) an instructor at an Oriental Medicine college who said any educational standards that are developed for Oriental Medicine should be established by the schools and not by an external body, and 5) the president emeritus of a wholistic health college who said when it comes to preventative medicine and the treatment of chronic degenerative diseases, CAM medicine is better suited than conventional medicine to provide treatment.

Specific Recommendations:

1. Appointment of naturopathic physicians to all agencies' committees' dealings with medical school curricula, hospital practice, and public health information dissemination.
2. Promote policies to allow licensed, trained naturopathic physicians to with closely with physicians as either consultants or in a primary role to help them better understand what naturopathy has to offer their patients.
3. Licensure of naturopathic physicians throughout the country to ensure public safety by requiring the highest level of education, training, and accountability.
4. Teach in-depth understanding of fundamental principles of CAM in medical schools including in-depth courses in herbs and nutritional supplementation; hospitals and physicians need to develop reliable networks for CAM referrals; fund collaborations between medical institutions and CAM schools in research.

Panel 11: Acupuncture and Oriental Medicine

In Panel 11, Commissioners heard testimony from: 1) a representative of an acupuncture society who said that acupuncture is not a single or simple technique or modality that can be added to a health care practice with an abbreviated survey-type course. Rather it requires thousands ours of training to be applied appropriately, 2) a physician and board-certified acupuncturists who said physicians that have completed appropriate training are more than qualified to provide not only safe, but efficacious, CAM care and bridge the gap between eastern and western medical practice, 3) a second-year acupuncture student who said that an accredited Oriental Medicine program involves approximately 2,200 hundred hours of study and training, including more than 1,000 hours of hands-on skills training, activities cannot be duplicated in an abbreviate course, 4) a visiting Chinese psychiatrist who practices Qigong who said there is an untapped wealth of data on medical Qigong in China, 5) the president a chiropractic practice council who said that any guidelines developed for chiropractic practice must be open to examining the best available clinical evidence and not be straightjacketed by being limited to evidence from randomized clinical trials, and 6) a physician who is also an acupuncturist and chiropractor who said that CAM practitioners need to be taught how to work as members of a healthcare team and to be more attuned to looking for adverse reactions and treatment failures in their patients.

Specific Recommendations:

1. Commission should examine the existing credentialing bodies for guidance and support the standards of education in acupuncture and oriental medicine and not

support abbreviated training programs that greatly diminish existing standards of competency and training, and diminish the quality of care.

2. The establishment of a Qigong research center to give practitioners a greater understanding of science and medicine and give researchers a better understanding of the potential medical applications of Qigong.
3. Promote more cross-training in CAM education schools (i.e., teach acupuncturists what chiropractors do, and vice versa).

Panel 12: CAM and Cancer

In Panel 12, the Commissioners heard from: 1) the director of a integrative medicine program at a cancer center who said her program offers a wide variety of complementary therapies, but not alternatives for which there is little evidence of benefit, 2) a cancer patient who said her metastatic cancer was successfully stabilized and is slowly regressing as a result of a combination of chemotherapy and herbal medicine, 3) the director of an institute on East-West medicine who said for CAM to become more accessible and transparent, it will need to win the complete trust of the conventional medical community, 4) an oncology social worker who said that many cancer patients base their decisions to use CAM on incomplete or anecdotal evidence from family and friends or on personal beliefs or preferences, 5) a breast cancer survivor and chair of several CAM committees who said cancer patients face a daily a quagmire of information about complementary medicine, and 6) a certified nutritionist and a cancer survivor who said that the American Dietetic Association should not be the only

organization that can certify individuals to provide nutritional information and education, particularly in schools where it is reliable information is needed the most.

Specific Recommendations:

1. Promote high quality research that will be above reproach.
2. Develop quality CAM education programs at the postgraduate level (e.g., internship, residency, and fellowship). Develop appropriate rotations in CAM during postgraduate training to allow younger physicians to appreciate and to develop the consciousness of what CAM practice means at a deeper level.
3. Development of a Web site that includes a listserv where physicians, other health care professionals, and the public can have ongoing access to a variety of different types of information on CAM (e.g., fact sheets on effectiveness of various CAM modalities, questions that one can ask a practitioner when considering a particular CAM approach, resources where one can locate qualified CAM practitioners, and guidelines for both health care professionals and patients to use to communicate with each other about the use of CAM.
4. Urge states to revise their continuing education requirements to include CAM (consider instituting a standardized model, such as the EPIC program used for end of life issues, which would be about CAM).
5. Establishment of a CAM advocate corp composed of designated, educated, and trained representatives who would be regularly updated by the national office on CAM. These people could then disperse reliable CAM information to their

respective networks, through existing publications, e-mail, gatherings of their special interest groups, etc.

6. Development of a more uniform ruling on who can legally call themselves a certified nutritionist.

Panel 13: Faith-Based CAM and Traditional Chinese Medicine

In Panel 13, Commissioners heard from: 1) two representatives of a church-based wellness center who said that faith-based communities are well-suited for providing access to CAM in a cost effective way that can reach large numbers of people in need, 2) the president of an Ayurveda holistic medical center and Ayurveda school who said Ayurveda is a complete system of medicine that offers a cost-effective means of both treating and preventing serious illness, 3) the vice president of a Traditional Chinese Medicine foundation who said it is critical for the general American public to have access to information on "authentic" traditional Chinese medicine not just traditional modalities taken out of context, 4) a licensed acupuncturist and medical director of natural health care center who said Chinese herbs can effectively treat many conditions but if used out of context by poorly trained practitioners they can also do great harm, and a 5) a representative of a Chinese Herbalists society who said there are significant differences between the training of herbal practitioners and acupuncturists and a significant distinction between traditional Chinese medicine and Chinese herbs.

Specific Recommendations:

1. Consider using faith-based communities as allies in making CAM available to people who need it the most (e.g, elderly, homeless, children, etc.).
2. Development of a national and state practitioner regulatory committee based on the Minnesota model.
3. Support public service announcements to ensure the dissemination of the finest quality of educational material on Traditional Chinese Medicine to the American public.
4. Efforts to recognize the different roles of Chinese herbs (i.e., they are not restricted to its medical use only) and refrain from restricting access of Chinese herbs by legislation.

Panel 14: Community-Based CAM Providers

In Panel 14, Commissioners heard from: 1) a professor of social welfare who said CAM is ancestral medicine and offers way to preserve the intellectual property of many things everyone's ancestors used decades and even centuries before modern medicine came on the scene, 2) a nurse practitioner who said she has been collecting anecdotal data on CAM usage by her patients since 1954 and she believes that such data should be systematically incorporated in data collected by health care providers throughout the country, 3) the chairperson and founder of a lay CAM health center who said the people who visit her health center do not tell their conventional doctors about the vitamins and herbs they receive there because they do not want to be cut off from their conventional health center, 4) a private-practice CAM provider who said she faces many challenges, including constant criticism from conventional medical doctors, lack of health insurance coverage for her services, and the inability to publicly advertise her services as a

legitimate healthcare provider, 5) the dean of a school of social work and the chair of a wellness center who said the federal government has a responsibility to ensure that the public has access to currently available information CAM services so that they can make informed decisions and to ensure that allopathic physicians and health care providers are aware of these CAM practices their patients may be utilizing, and 6) a psychiatrist and consultant to a homeless organization who said Medicaid restraints often make providing CAM care to the homeless a challenge and efforts to more favorably affect Medicaid coverage will permit much more of the homeless population access to CAM approaches.

Specific Recommendations:

1. Develop policies that are inclusive and not exclusive of CAM health care providers who are not licensed medical doctors, particularly in regard to providing culturally relevant health care services. \
2. Provide the public with accurate information on the risks and benefits of so-called natural substances.
3. Take action to ensure that what is on the contents label of a nutritional or herbal supplement package is in fact what is in the package.
4. Develop programs to improve communication between patients and allopathic health care providers about both CAM and allopathic treatments that patients are using.

Panel 15: CAM and AIDS

In Panel 15, Commissioners heard from: 1) deputy executive director of an organization dedicated to serving former inmates with HIV who said CAM as the cost effective way of dealing with prevention and illness, and policies are needed that help our prison system to cease being a warehouse of humanity and start becoming a center of re-education for a very captive audience, 2) an assistant vice president of organization that offers CAM and conventional treatments for AIDS patients who said clinic attendance is higher on days when CAM therapies are offered and those patients who incorporate CAM into their treatment have less substance abuse and better compliance with their medical therapy, 3) the director of planning and development at a health center who said CAM has for generations been the first line of health care for the many Latinos and African Americans in her community, many who have HIV, 4) a representative of a victim support center who said in the community which she works their is an extraordinarily high rate of heart disease, stroke, diabetes, and other diet related health problems and an inordinate number of black boys, ages five to fifteen, who have been diagnosed with attention deficit disorder or other related disorders. She said that little is being done to educate this community about proper diet and nutrition.

Specific Recommendations:

1. Establish standards of care that permit patients to receive CAM treatments, such as acupuncture, massage therapy, nutrition therapy, and other remedies as medical services within state licensed medical care facilities with adequate Medicaid and Medicare reimbursement rates.

2. Encourage managed care plans to treat CAM services as a "carve out" product that supports self care and wellness benefits that such plans promote as health maintenance goals.
3. Develop programs to promote better nutrition in vulnerable populations.

Panel 16: Acupuncture and Traditional Oriental Medicine

In Panel 16, Commissioners heard from: 1) a Qi FeiLong grand master who gave a demonstration of internal Chi, 2) president of a licensed acupuncture association who said acupuncture is a low-cost, effective treatment for a range of painful problems, 3) a board member of an acupuncture society who said the "biggest threat" to American's health involves the use of traditional Chinese herbal medicine and acupuncture by untrained or minimally-trained persons, and 4) an acupuncture patient who said acupuncture not only relieves pain but also increases energy levels and benefits the immune system.

Specific Recommendations:

No specific recommendations were offered.

Panel 17: Movement Therapies

In Panel 17, Commissioners heard from: 1) two Reiki masters who said that Reiki, which is laying on of hands and a spiritual healing art, should not be subject to control, licensing, or other oversight either by federal or state governments, 2) a representative of an Alexander Technique (AT) society who said that AT isn't medicine, traditional or

otherwise, but rather teach people to become aware of maladaptive habits and behaviors and to prevent them, and 3) a representative of a movement therapy association who said that current CAM classification developed by NCCAM are hurting practitioners of movement therapies such as Alexander Technique and others because it is being used by State regulatory agencies to classify movement therapies into categories where the do not belong (e.g., massage).

Specific Recommedations:

1. The practice of Reiki should be kept free and protected from all government regulation.
2. The classification of Alexander Technique as a health education system rather than a medical therapy.
3. Development federal guidelines for modalities such as Reiki and Alexander Technique that allow them to voluntarily and responsibly self-regulate themselves.
4. The development of more research models that incorporate qualitative studies, combined quantitative and qualitative approaches, and single subject analyses as well as multi-variate analyses to better inform the public about complex and overlapping aspects of human movement and general behavior.

Panel 18: CAM Integration and Reimbursement

In Panel 18, Commissioners heard from: 1) a consultant in strategic planning in emerging medical technologies who said there is a great need for new information services and

educational resources that embrace all the world's health and medical disciplines and a new health care systems that respect all modalities, 2) a representative of an alternative healing center who said CAM modalities that prove to be effective deserve to be included in payment plans by insurance companies and HMOs, 3) the executive officer of a chiropractic organization who said that chiropractic is not the diagnosis and treatment of disease, but rather the detection and correction of vertebral subluxation, which people use regardless of disease, for the purposes of improving their overall health and well-being and quality of life, 4) the director of a professional services health organization who said the key elements to true integrative medicine are to differentiate condition treatment from health care management and to recognizing as a truth in practice that health is more than the mere absence of disease, and 5) a sacral cranial therapist who said cranial sacral therapy is clinically and economically cost-effective in providing symptomatic relief to a wide variety of orthopedic and neurological disabilities.

Specific Recommendations:

1. Make health and wellness of everyone a national priority at the highest level.

Panel 19: Wellness and Natural Health

In Panel 19, Commissioners heard from: 1) the director of a wellness program who said medicine must begin to focus on prevention and health education, by teaching everyone the basics of how to care for themselves through good nutrition, exercise, and stress management, including conflict resolution and communication skills, 2) a founding member of a natural health coalition who said many, if not the vast majority, of CAM

users see unregulated practitioners and that overzealous regulatory agencies are putting the health of people at risk by trying to limit access to these practitioners, 3) a CAM student who said the very nature of alternative healing practices is damaged by third-party intervention, and 4) an M.D. and board certified herbalist who said most reports of herbal toxicity are actually do to misuse, abuse, and limited knowldege of medical herbs and herbal products.

Specific Recommendations:

1. Commission should broaden the views of state regulators on allowing access to CAM practitioners.
2. Any herbal store, including on-line retailers, who sell potentially toxic herbs or herbal products should have a qualified herbalist on site with whom customers can consult on the toxicity, dosage, contraindications, and other available scientific information before making a purchase.

Panel 20: Miscellaneous

In Panel 20, Commissioners heard from: 1) a CAM consumer who said that many herbalist she has seen were not properly trained and thus did more harm than good, 2) a Tai Chi instructor who said that CAM therapies have helped many members of his family, 3) two respresenatives of a natural health coalition who said is would be inappropriate for a federal agency, department, or advisory board to mandate or even recommend a process or guideline for licensure of CAM practitioners, and 4) a health and medical writer who said most frustrating aspect of covering alternative medicine is that

there are few studies one can read and experts one can interview about a particular treatment.

Specific Recommendations:

1. White House Commission should limit its activities to expediting the flourishing of the natural health in this country, not to restricting it.
2. Encourage the advancement of natural health freedom bills such as the one passed in Minnesota.

Panel 21: Miscellaneous

In Panel 21, Commissioners heard from: 1) a science writer who has been covering CAM for more than 20 years who said there is a general lack of high-quality information on CAM on the Internet where most people get their health information, 2) the general counsel for a nutritional foods association who said her organization supports further research on nutritional products so that there's adequate and reliable substantiation for all statements made on product labels and in advertising, and 3) two chiropractors who are founders of a children's wellness foundation who said children are especially susceptible to vertebral subluxation and it is vital to recognize that chiropractic care for children in a wellness-based vitalistic health care model, not as a treatment for symptoms or disease.

Specific Recommendations:

1. Allocate resources immediately to expanding Web sites devoted to CAM. These sites can provide abundant resources without making specific recommendations.

Such responsibilities should be put in the hands of people who are technically astute at accessing the information and putting it online without having an ax to grind in this field. In other words, the attempt at some kind of neutrality, but technical expertise.

2. Develop more effective strategies to educate and distribute information on chiropractic care for children to parents.

Panel 22: Miscellaneous

In Panel 22, Commissioners heard from: 1) an registered nurse and Reiki practitioner who said she has seen Reiki and therapeutic touch show great benefit for Alzheimer's patients, 2) several representatives of a nutritionally based program for children with attention behavior and learning problems who said dietary management needs to be among the options parents are given by their medical professionals for the treatment of attention behavior and learning problems, and 3) a woman who said that attention deficit and hyperactivity disorders run in her family and that her children have received immense benefit from nutritional approaches to their condition.

Specific Recommendations:

1. Inclusion of dietary approaches in any current and future effort to address public health concerns related attention deficit and behavioral and learning problems.
2. Provide assistance in mandating and funding further research needed to address unresolved issues related to diet, such as those documented in that NIH consensus development statement on ADHD.

Groft, Stephen (NCCAM)

From: HVBradford@cs.com

Sent: Thursday, April 26, 2001 11:03 AM

To: Groft, Stephen (NCCAM); paul_a_armond@groton.pfizer.com; acuman@aaom.org; rgellman@ahpa.org; dbmas@earthlink.net; cherlihy@nccaom.org; mrussell@nimc.org; julia.goldrosen@onemedicine.com

Subject: CAM Communications and Reports #4

CAM Communications and Reports Issue 4

White House Commission on Complementary and Alternative Medicine Policy Meetings

CAM Information Development and Dissemination, March 26, 2001
CAM in Self-Care and Wellness, March 27, 2001

People rely more on themselves and less on their physicians for health care information as a result of several trends: expansion of health information resources, especially websites and newsletters; increased mainstream media news coverage of health in general and CAM in particular; and heightened desire for consumer decision making in health care. The implications of these trends were examined during this fourth policy hearing of the White House Commission on Complementary and Alternative Medicine Policy.

The first day opened with responses to these trends from large scientific and commercial news sources, followed by recommendations from both presenters and Commissioners on how to focus the federal government's response. The second day's testimony and policy recommendations concerned the state of self-care and wellness programs.

Information Development and Dissemination

The first panel included representatives of The Washington Post, National Public Radio, CBS Evening News, Time Magazine, Prevention Magazine, The UC Berkeley Wellness Letter, Ask Dr. Weil, and The National Library of Medicine. The clear message given by all presenters was that most national news organizations have greatly expanded their coverage of CAM in the last few years and have, in large part, discontinued their dismissive attitude towards CAM therapies. At the same time, they have put more resources into analysis of CAM-related issues and toughened their approach to reporting on both conventional medicine and CAM stories. The overriding concern mentioned by several presenters and Commissioners is that health care providers are unprepared to help consumers evaluate this wealth of CAM information.

In light of these concerns, individual presenters and Commissioners proposed the following actions for the full Commission's consideration:

1) Fund development of CAM curriculum for all medical and pharmacy schools.
2) Foster more CAM research in treatment options, diagnostic techniques, and clinical practice.
3) Support education for public librarians on searching health care literature.
4) Incubate, through support to the National Library of Medicine, a

consortium of CAM-related websites to set standards and information evaluation policies for websites.
5) Create a press office at the federal level to serve as the "resource of first contact" on CAM-related issues.
6) Provide grants to neutral CAM websites to upgrade databases.

Subsequent panels, representing the Center for Science in the Public Interest, The Federal Trade Commission (FTC), The Food and Drug Administration (FDA), The American Pharmaceutical Association, The Pew Internet & American Life Project, Consumer Reports and others, discussed their responses to the complex information and regulatory problems posed by the rapid expansion of CAM.

Recommendations included:

1) Appropriate adequate funds to the FDA to implement DSHEA, and to the FTC to enforce relevant trade regulations.
2) Strongly recommend publication of Good Manufacturing Practices Guidelines by FDA.
3) Recommend that herbal manufacturers increase information available to consumers at the point of purchase, through package inserts for herbal products and other sources of specific information on herbal product indications, use, and cautions.
4) Consider creation of a separate regulatory class for dietary supplements, rather than current placement in the category of food (or the other available category of drugs).
5) Create a coordination office for CAM practice and products, perhaps at the level of the Assistant Secretary of the Department of Health and Human Services or in the White House Office of Domestic Policy.
6) Create a tax on dietary supplements to fund a public education campaign on use of herbs, vitamins, minerals and other common dietary supplements.
7) Encourage the National Center for Complementary and Alternative Medicine at the National Institutes of Health to create more fact sheets on CAM therapies and products.

Self-Care and Wellness

The Self-Care and Wellness program included presenters from the University of Maryland's Complementary Medicine Program, the American Academy of Pediatrics, Harvard School of Public Health, the College of Physicians in Philadelphia, the American Dietetic Association, Metagenics, Canyon Ranch, the Center for Mindfulness, Medicine, Health Care, and Society at the University of Massachusetts, and the George Washington University School of Medicine. The range of topics included spirituality, classical nutrition counseling, functional medicine, spa programs, primary care wellness consultations and patient advocacy programs.

Recommendations for federal initiative were:

1) Develop a comprehensive program to educate the public and providers on the use of nutrition to prevent and treat disease as well as to promote health.
2) Find ways to make whole foods as cheap and accessible as processed foods and to support development of a sustainable agricultural economy.
3) Fund demonstration projects on 1) the impact of multifactor nutritional supplements on health promotion and disease prevention and 2) cost effectiveness of wellness.
4) Encourage health care providers to model wellness.
5) Increase funding for research on models of wellness.
6) Forgive student loans for providers who deliver wellness services.
7) Increase reimbursement for wellness services and support reduction of health insurance premiums for individuals who undertake wellness practices.

8) Encourage the media to promote wellness in their culture.

The final Commission hearing, on Research and Reimbursement, is scheduled for May 14-16, 2001 in Washington, D.C. Starting in July, there will be a series of meetings to review the Commission's Report:

July 2-3, 2001	***review interim Report Draft***
October 4-5, 2001	***Progress on the Final Report***
December 6-7, 2001	***Review Final Report***
March 2002	***Closing Event (date to be determined)***

The May issue (#5) will cover the May research and reimbursement hearing and the prior research hearing. The June issue (#6) will review recommendations related to education and training not covered in other reports.

In July, September, October, November and December (Issues #7 through #11) CAM Communications and Reports will report on the status of the Commission's report and resulting legislative and regulatory proposals. In place of an August issue, a final report (Issue #12) on the March 2002 Closing Event will be sent to subscribers.

For more information, contact the White House Commission on Complementary and Alternative Medicine Policy, 6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817-7707, 301-435-7592, fax 301-480-1691, email whccamp@od.nih.govwebsite: www.whccamp.hhs.gov

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Groft, Stephen (NCCAM)

From: Groft, Stephen (NCCAM)

Sent: Thursday, April 26, 2001 1:55 PM

To: Albrecht, Joan (NCCAM); Axelrod, Corinne (NCCAM); Chang, Michele (NCCAM); Fisher, Ken (NCCAM); Jim Swyers; Kaczmarczyk, Joseph (NCCAM); Kingsbury, Doris (NCCAM); Miller, Maureen (NCCAM); Pollen, Geraldine (NCCAM)

Subject: FW: CAM Communications and Reports #4

-----Original Message-----
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Subject: CAM Communications and Reports #4

CAM Communications and Reports Issue 4

White House Commission on Complementary and Alternative Medicine Policy Meetings

CAM Information Development and Dissemination, March 26, 2001
CAM in Self-Care and Wellness, March 27, 2001

People rely more on themselves and less on their physicians for health care information as a result of several trends: expansion of health information resources, especially websites and newsletters; increased mainstream media news coverage of health in general and CAM in particular; and heightened desire for consumer decision making in health care. The implications of these trends were examined during this fourth policy hearing of the White House Commission on Complementary and Alternative Medicine Policy.

The first day opened with responses to these trends from large scientific and commercial news sources, followed by recommendations from both presenters and Commissioners on how to focus the federal government's response. The second day's testimony and policy recommendations concerned the state of self-care and wellness programs.

Information Development and Dissemination

The first panel included representatives of The Washington Post, National Public Radio, CBS Evening News, Time Magazine, Prevention Magazine, The UC Berkeley Wellness Letter, Ask Dr. Weil, and The National Library of Medicine. The clear message given by all presenters was that most national news organizations have greatly expanded their coverage of CAM in the last few years and have, in large part, discontinued their dismissive attitude towards CAM therapies. At the same time, they have put more resources into analysis of CAM-related issues and toughened their approach to reporting on both conventional medicine and CAM stories. The overriding concern mentioned by several presenters and Commissioners is that health care providers are unprepared to help consumers evaluate this wealth of CAM information.

In light of these concerns, individual presenters and Commissioners proposed the following actions for the full Commission's consideration:

1) Fund development of CAM curriculum for all medical and pharmacy schools.
2) Foster more CAM research in treatment options, diagnostic techniques, and clinical practice.
3) Support education for public librarians on searching health care literature.
4) Incubate, through support to the National Library of Medicine, a consortium of CAM-related websites to set standards and information evaluation policies for websites.
5) Create a press office at the federal level to serve as the "resource of first contact" on CAM-related issues.
6) Provide grants to neutral CAM websites to upgrade databases.

Subsequent panels, representing the Center for Science in the Public Interest, The Federal Trade Commission (FTC), The Food and Drug Administration (FDA), The American Pharmaceutical Association, The Pew Internet & American Life Project, Consumer Reports and others, discussed their responses to the complex information and regulatory problems posed by the rapid expansion of CAM.

Recommendations included:

1) Appropriate adequate funds to the FDA to implement DSHEA, and to the FTC to enforce relevant trade regulations.
2) Strongly recommend publication of Good Manufacturing Practices Guidelines by FDA.
3) Recommend that herbal manufacturers increase information available to consumers at the point of purchase, through package inserts for herbal products and other sources of specific information on herbal product indications, use, and cautions.
4) Consider creation of a separate regulatory class for dietary supplements, rather than current placement in the category of food (or the other available category of drugs).
5) Create a coordination office for CAM practice and products, perhaps at the level of the Assistant Secretary of the Department of Health and Human Services or in the White House Office of Domestic Policy.
6) Create a tax on dietary supplements to fund a public education campaign on use of herbs, vitamins, minerals and other common dietary supplements.
7) Encourage the National Center for Complementary and Alternative Medicine at the National Institutes of Health to create more fact sheets on CAM therapies and products.

Self-Care and Wellness

The Self-Care and Wellness program included presenters from the University of Maryland's Complementary Medicine Program, the American Academy of Pediatrics, Harvard School of Public Health, the College of Physicians in Philadelphia, the American Dietetic Association, Metagenics, Canyon Ranch, the Center for Mindfulness, Medicine, Health Care, and Society at the University of Massachusetts, and the George Washington University School of Medicine. The range of topics included spirituality, classical nutrition counseling, functional medicine, spa programs, primary care wellness consultations and patient advocacy programs.

Recommendations for federal initiative were:

1) Develop a comprehensive program to educate the public and providers on the use of nutrition to prevent and treat disease as well as to promote health.
2) Find ways to make whole foods as cheap and accessible as processed foods

and to support development of a sustainable agricultural economy.
3) Fund demonstration projects on 1) the impact of multifactor nutritional supplements on health promotion and disease prevention and 2) cost effectiveness of wellness.
4) Encourage health care providers to model wellness.
5) Increase funding for research on models of wellness.
6) Forgive student loans for providers who deliver wellness services.
7) Increase reimbursement for wellness services and support reduction of health insurance premiums for individuals who undertake wellness practices.
8) Encourage the media to promote wellness in their culture.

The final Commission hearing, on Research and Reimbursement, is scheduled for May 14-16, 2001 in Washington, D.C. Starting in July, there will be a series of meetings to review the Commission's Report:

July 2-3, 2001	***review interim Report Draft***
October 4-5, 2001	***Progress on the Final Report***
December 6-7, 2001	***Review Final Report***
March 2002	***Closing Event (date to be determined)***

The May issue (#5) will cover the May research and reimbursement hearing and the prior research hearing. The June issue (#6) will review recommendations related to education and training not covered in other reports.

In July, September, October, November and December (Issues #7 through #11) CAM Communications and Reports will report on the status of the Commission's report and resulting legislative and regulatory proposals. In place of an August issue, a final report (Issue #12) on the March 2002 Closing Event will be sent to subscribers.

For more information, contact the White House Commission on Complementary and Alternative Medicine Policy, 6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817-7707, 301-435-7592, fax 301-480-1691, email whccamp@od.nih.govwebsite: www.whccamp.hhs.gov

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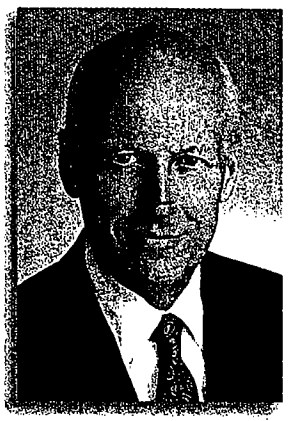
The road to be taken: AOA leadership on complementary and alternative medicine



JOHN B. CROSBY, JD

For many years, DOs have felt they offered "the alternative" to care provided by MDs. In many respects, DOs still do, given the growing number of American patients who are flocking to our doorsteps for quality, cost-effective healthcare. Like the poet Robert Frost, patients are taking the less-traveled road and learning what the complementary "DO difference" is all about.

But a new road has appeared in the woods that is making it difficult for physicians, patients and policy-makers to distinguish the forest from the trees. That road is paved by complementary and alternative medicine (CAM).

Where did this new road come from?

At one time, CAM was attributed to the managed care blues. Later, it was ascribed to a return to a simpler, more natural way of living. Recently it has been criticized as the latest chapter of the increasingly profit-driven healthcare industry.

> "Two roads diverged in a wood, and I—I took the one less traveled by, and that has made all the difference."
> —*Robert Frost*

Whatever its cause, its effect is undisputed. CAM has become a booming business, and it is changing the way traditional healthcare providers approach medicine. The question of the hour is which road the AOA should take.

Understandably, many osteopathic physicians fear associating in any way with alternative practitioners. Some DOs believe that by becoming familiar with CAM therapies, they would inadvertently be validating otherwise unscientific methods. These DOs are even concerned that their standard medical practices would be called into question if they used any CAM therapies.

Patients do not share this skepticism. Since 1997, Americans have spent more than $27 billion per year on CAM, exceeding out-of-pocket spending for all hospitalizations in the United States.

Clearly, CAM is not going away. DOs can join the growing number of healthcare professionals who are providing leadership on this issue, or they can ignore their patients' wishes to take advantage of CAM. I believe the best choice for osteopathic physicians is the first.

CAM captures nation's attention

According to major studies published in *The Journal of the American Medical Association*, consumer demand for CAM services experienced a major upswing in the second half of the 1990s. During this time, several think tanks on alternative practices were created. The most notable of these is the National Center on Complementary and Alternative Medicine (NCCAM).

The US Congress established NCCAM in 1998 as part of the National Institutes of Health (NIH). Congress charged NCCAM with stimulating, developing and supporting research on CAM for the benefit of the public. NCCAM advocates quality science, rigorous and relevant research, and open and objective inquiry into which CAM practices work, which do not and why. The agency's overriding mission is to give the public reliable information about the safety and effectiveness of CAM practices.

Although osteopathic medicine is *not* among the "alternative practices" that fall under NCCAM's consideration, AOA members and AOA staff are par-

ticipating in national discussions to gather information on CAM therapies.

For example, Capt Joseph M. Kaczmarczyk, DO, MPH, USPHS, works with NIH's Office of Alternative Medicine. Additionally, he serves as the senior medical adviser to the White House Commission on Complementary and Alternative Medicine Policy. Created by executive order in March 2000, the White House commission is developing licensure and practice regulations for CAM that will be submitted to President George W. Bush in March 2002.

As the nation examines regulatory policies on CAM, the osteopathic medical profession's incentives for taking a leadership role on this issue deepen in many respects, especially with regard to medical education.

A changing classroom

Policy-makers and patients are not the only ones who are open to the possibilities of CAM. Medical educators are taking a hard look at how CAM relates to conventional medicine.

According to the Association of American Medical Colleges, at least 70 allopathic medical schools currently offer course work in CAM. In addition, Harvard University recently received a $10 million grant from the San Francisco-based Bernard Osher Foundation to investigate CAM practices.

These factors indicate that the time is right to actively promote the virtues of osteopathic manipulative treatment and osteopathic principles. For the past several decades, DOs' fears of being perceived as different have overshadowed their desires to trumpet their unique skills. Now, patients view unique skills and approaches as "hot tickets" in healthcare.

While the osteopathic medical profession does not want to associate itself with unproven or fad treatments, it should capitalize on the resources now available to study new and differing treatments. The nation's current openness to emerging treatments and to rethinking rigid conventions can only benefit the profession and its new programs, such as the osteopathic research center that the AOA and several other osteopathic medical organizations are developing.

Taking a stand

In the face of ongoing public discussions on CAM, some factions of the osteopathic medical profession have criticized the AOA for not taking a clearer position on alternative practices. Time and time again, the AOA has been invited to participate in national dialogues on CAM. But given the professionwide reluctance to embrace CAM therapies, the only message we have been able to communicate is that osteopathic medicine should not be grouped with CAM.

It is time for the profession to stop being ambivalent about CAM. Joining coalitions of medical organizations for the purpose of evaluating CAM will not in any way diminish the stature of osteopathic medicine in the medical world. Instead, participating in such coalitions would allow us to share information about osteopathic principles and practice. That can only help the profession in a time when terms like *holistic* and *self-healing* are becoming household words.

What are your views on this controversial issue? Which road do you feel we should take? The members of the AOA House of Delegates will have a chance to weigh in on this issue at their annual meeting in Chicago in mid-July. The delegates will consider a resolution promulgated by the AOA Committee on Health Related Policies that recommends the AOA form a task force to develop a definitive position on CAM.

Keeping patients foremost in mind

In its collection of public education fact sheets on CAM therapies, NCCAM offers the following advice to patients considering CAM providers: "Competent healthcare management requires knowledge of both conventional and alternative therapies for the practitioner to have a complete picture of your treatment plan."

Recognizing the validity of such an approach, the American Academy of Osteopathy (AAO) recently honored Andrew Weil, MD, a Harvard-trained physician credited with founding the "integrative medicine" movement. The AAO saluted Dr Weil for recognizing OPP in his academic model for "integrative medicine," which includes a sampling of today's most effective practices.

Adopting a best-of-both-worlds viewpoint will have direct benefits for osteopathic medicine, which for more than 100 years, has focused on treating the whole person, not just symptoms.

Maybe if those patients who seek a different kind of physician had more information about osteopathic medicine, they wouldn't look any farther than the nearest DO. They would follow our road.

John B. Crosby, JD
AOA executive director

Contact us with your thoughts

Readers interested in expressing their opinions on how the osteopathic medical profession should address complementary and alternative medicine are invited to submit letters to the editor to The DO.

The letters should be sent be as double-spaced typewritten drafts to the attention of Gilbert E. D'Alonzo Jr, DO, editor in chief, American Osteopathic Association, 142 E. Ontario St, Chicago, IL 60611-2864.

With word-processed documents, please send electronic copies on diskettes along with the typewritten letters. Word-processed documents also can be sent by e-mail to TheDO@aoa-net.org.

The DO reserves the right to edit and shorten letters.