Education and Training of Health Care Practitioners in CAM

Staff Lead: Joe Kaczmarczyk
Members: George Bernier (Facilitator), Joe Pizzorno (Facilitator), David Bresler, Joe Fins, Buford Rolin, and Donald Warren

Summary of Education and Training Issues:

- Access to funding and other resources for CAM faculty, curricula, and program development
- National educational standards to practice CAM
- Basic or core conventional health curriculum for CAM students and practitioners
- "Traditional Healing" education and training
- Participation of CAM students in scholarship and loan programs
- Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels
- Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers

Issue 1. Access to funding and other resources for CAM faculty, curricula, and program development.

Background: Representatives from CAM institutions and professional and educational organizations recommended improving access to funding and other resources for CAM faculty, curricula, and program development. Theoretically, this could result primarily in better CAM education and training, better trained CAM practitioners, and better quality of CAM services. Secondarily, this may attract more CAM students and perhaps eventually increase the number of well-trained CAM practitioners. One of the ways in which this improved funding can be approached is through amending Titles VII and VIII of the PHS Act which could authorize Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr) to provide this type of funding perhaps at the expense of other programs.

During FY2000, NCCAM awarded research grants to Bastyr University, Maharishi University of Management, and Palmer College of Chiropractic. The majority of support from NCCAM was given to conventional institutions. According to testimony provided on February 22, 2001 by Mr. Neal Sampson, Deputy Associate Administrator, HRSA's Bureau of Health Professions, "The Bureau of Health Professions' involvement in training and education programs on CAM, at this point, is very limited. The Bureau's Division of Nursing currently funds three graduate programs that include content on complementary and alternative therapies. And BHPr funds the Chiropractic Demonstration Project Grants Program, which supports research projects where chiropractors and physicians collaborate to identify and provide effective treatment for spinal and lower-back conditions. Currently, research is the only activity legislatively authorized under this program... All of the Bureau's Title VII and VIII training and

education programs are established through specific legislation in the Public Health Service Act. These programs are directed toward specific health disciplines and, as a result, we have very little leeway in how we allocate funds."

Challenges: The challenges include availability of funding in an era of diminishing resources and increased competition for all available resources, conventional health professions organizational and institutional resistance, equitable identification and prioritization of CAM recipients of increased funding, and ultimately the need for Federal legislation and appropriations.

Draft Recommendations:

1. Appropriate access to funding and other resources for CAM faculty, curricula, and program development at accredited institutions and by licensed professions by amending Titles VII and VIII of the PHS Act to authorize Health Resources and Services Administration, Bureau of Health Professions to provide this type of funding is recommended.
2. Joint research and educational programs involving CAM practitioners and conventional practitioners should be established and financial support for these programs should be identified.

Issue 2. National Educational Standards to Practice CAM.

Background: On February 22, 2001, during the WHCCAMP meeting on Education and Training, the Commissioners in Discussion Group #4 indicated that there should be national educational standards for CAM modalities, therapies, and practices established by professional and educational institution organizations linked with the proposed Federal CAM coordinating office. They also expressed that these standards should include exposure to not only a variety of commonly utilized CAM modalities, therapies, and practices, but also conventional health care. In addition, these Commissioners endorsed creating a professional role for RNs, LCSWs, and others as a "Care Navigator," as envisioned by Richard Miles in his testimony, to listen and coach consumer on referral in a manner that preserves consumer choice and safety.

Despite the large number of practices, therapies, modalities, disciplines, and professions involved which make this an exceedingly complex issue, the House of Lords Select Committee on Science and Technology (Sixth Report: Complementary and Alternative Medicine, 21 November 2000, Chapter 6: Professional Training and Education) stated: "We recommend that CAM training courses should become more standardized and be accredited and validated by the appropriate professional bodies. All those who deliver CAM treatments, whether conventional health professionals or CAM professionals, should have received training in that discipline independently accredited by the appropriate regulatory body." They went on to say, " This would protect the public who use CAM and would improve the transparency of the organizations and make understanding what practitioners' qualifications mean easier. It is clear to us that the quality and degree of standardization of training within each therapy are closely linked to

how successful each individual therapy has been in overcoming internal divisions and coming together under the auspices of a single body that agrees core objectives for education and regulation."

Challenges: The challenges include similarity to licensure and perceived encroachment on States' rights, degree of complexity, multiple contentious issues, funding requirements, need for legislation and appropriations, questionable authority, and wide-spread resistance.

Draft Recommendation:

3. National educational standards for CAM modalities, therapies, and practices need to be established by professional and educational institution organizations linked with the proposed Federal CAM Coordinating Office.

Issue 3. Basic or core conventional health care health care curriculum for CAM students and practitioners.

Background: A basic or core curriculum for CAM students and practitioners was suggested to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers. This core curriculum should include information on an evidence-based approach to health care (including specific training in critiquing CAM trials), conventional health care (including referral to conventional health care providers), and other CAM modalities and systems of heath care. By learning about other CAM modalities and systems of care, CAM students and practitioners could learn how and when to refer to other CAM practitioners.

After acknowledging a deficiency in CAM training for allopathic students, Caspi et al. (Arch Intern Med 2000;160:3193-3195) asserted that there "should be a perfectly symmetrical process, ie, that the depth and breadth of the training of CAM practitioners should be such that they would be able to speak the biomedical language." These authors expressed concern about lack of exposure of CAM students "to allopathy and its related sciences."

Challenges: The challenges include professional, organizational, and institutional resistance; funding; providing adequate incentives to adopt these curricula; numerous logistical design, development, and implementation issues; achieving consensus of curricula; availability of adequately trained faculty and faculty development; and ability to make any addition to very full curricula.

Draft Recommendations:

4. A basic curriculum in conventional health care and medical sciences is recommended for CAM students and practitioners to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers.

5. Encourage and fund collaboration between CAM and conventional health care institutions.

Issue 4. Traditional Healing Education and Training.

Background: Since traditional healing falls under the rubric of CAM, numerous questions are possible. For example, who should be allowed to use the title "Traditional Healer" and what education and training are necessary to be designated a "Traditional Healer?" In addition, to whom should traditional healing and other culturally-based healing practices be taught? Should they be reserved only for members of the culture of origin or should they be taught to anyone? How should traditional healing be taught? These questions have relevance to the Indian Health Service and Health Resources and Services Administration's Bureau of Primary Health Care.

Input from the Association of American Indian Physicians, Dine [Navajo] Medicine Association Inc., Papa Ola Lokahi, and Native Hawaiian healer Kawaikapuokalani Hewett was solicited and received for the February 22-23, 2001 meeting on Education and Training. Input also was received from Alaskan Natives after the February meeting. The aggregate input from American Indians, Native Hawaiians, and Alaskan Native supported continued application and practice of their traditions for designation, selection, education and training, self-regulation, and licensure exemption of Traditional Healers.

Challenges: The challenges include the definition of "Traditional Healing" and "Traditional Healer," funding, cultural sensitivity, questionable authority in this area, and wide-spread resistance to any outside intervention.

Draft Recommendation:

6. Traditional healers who practice within a community which provides traditions and oversight should be provided appropriate access to educational funding and allowed to continue to practice without State censure, providing:
    a. Their clients are fully informed of their training (or lack thereof)
    b. They do not mislead their clients by use of titles of licensed professions
    c. They have not been censured by their community.

Issue 5. Participation of CAM Students in Scholarship and Loan Programs.

Background: Participation in scholarship and loan programs was suggested by CAM students and representatives from CAM institutions and CAM professional organizations. This implies participation in Federal programs such as the National Health Service Corps (NHSC) scholarship and loan forgiveness programs. Recently, NHSC was relocated within HRSA by moving it from the Bureau of Primary Health Care (BPHC) to the Bureau of Health Professions (BHPr). Participation in NHSC scholarship and loan forgiveness programs is defined in authorizing legislation (PHS Act, Title III, Section 301) which is interpreted narrowly by NHSC. In other words, unless a health profession

is specifically named in authorizing legislation, members of that health profession cannot participate in NHSC programs.

NHSC meets approximately 12-15% of its need through exclusive participation of conventional health care providers. There is no CAM participation in NHSC programs at this time. Discussions with NHSC indicated that their preference is for loan forgiveness programs, because it is considerably easier for NHSC to match a fully trained provider through loan a forgiveness program than it is through a scholarship program.

The likelihood of CAM participation in NHSC programs is low for a number of reasons. First, NHSC meets such a small percentage of its need with conventional providers that there is a greater need for conventional health care providers than CAM practitioners. Second, legislation would have to delineate which CAM disciplines and practitioners would be eligible to participate in Federal programs. Third, there would need to be additional appropriations to fund CAM practitioner participation in these programs. Fourth, while there are guidelines for determining the number of a given type of conventional health care practitioner for a defined population size or geographic area, no such guidelines exist for CAM practitioners. In short, a more likely scenario would be CAM student and practitioner participation in State-funded programs.

Currently, there is a Senate--but not an accompanying House—draft NHSC reauthorization bill which includes chiropractors in a three-year demonstration. However, neither NHSC nor BHPr has conducted any type of financial analysis of the impact of inclusion of CAM students and practitioners in Federal scholarship and loan programs. Meanwhile, the most recent NHSC data indicate decreasing ability to meet identified need, meeting only 10% of the identified need in terms of conventional providers. NHSC expects to award only 300 new scholarships this year, while approximately 800 providers leave medically underserved areas per year. There are approximately 70 State programs not affiliated with NHSC.

Challenges: The challenges include preference for conventional health care providers to fill the largely unmet need, requirement for legislative and appropriations changes, identification of specific CAM disciplines and practitioners, and difficulty in administering CAM–inclusive programs particularly in the absence of population and geographic guidelines for CAM practitioners and financial impact data.

Draft Recommendation:

7. CAM students should be eligible for State and where appropriate national fiscal support based on service to designated areas. Eligibility would apply to loans, loan forgiveness, and scholarships. The next reauthorization of Titles VII and VIII of the Public Service Act should be amended to include enabling legislation making CAM students eligible.

Issue 6. Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.

Background: A basic or core CAM curriculum for conventional health care professionals in professional schools, postgraduate training programs, and continuing education programs was suggested to increase knowledge and understanding of CAM in order to enhance and protect the public's health. These curricula in CAM fundamentals and principles should be developed in conjunction with CAM experts and CAM institutions. These curricula should establish, to the extent possible, an evidence-based foundation for conventional health professionals to discuss CAM use with their patients, to make referrals to appropriately trained CAM professionals, and to develop an understanding of the interactions, either therapeutic or harmful, between conventional and CAM treatments to improve and safeguard their patients' health. The conventional health care professions for whom these curricula should be developed should include, but not be limited to, allopathic and osteopathic physicians, physician assistants, nurses, dentists, pharmacists, dieticians, psychologists, social workers, physical therapists, optometrists, and podiatrists.

This does not address the needs of those conventional health care professions students and providers who desire an "integrative" approach and wish to go beyond learning *about* CAM and learn *how* to provide CAM which is more appropriate in postgraduate and continuing education. However, impediments to doing so exist in the form of difficulty with or denial of approval of conventional residencies and continuing education programs which provide an opportunity for acquisition of CAM skills.

In an editorial, Berman (BMJ 2001;322:121-122) recounted, "In 1995 a national conference on complementary and alternative therapy education involving the National Institutes of Health recommended that complementary and alternative therapy should be included in nursing and medical education." Although Wetzel et al. (JAMA 1998;280:784-787) reported that 64% of allopathic medical schools offered elective courses in CAM or included these topics in required courses, most were stand-alone CAM electives with contact time varying from 6-160 hours. Bhattacharya (J Alt Comp Med 2000;6:77-90) provided a compilation of groups with curricular initiatives; however, heterogeneity of content, format, and requirements is apparent. Recently, NIH NCCAM awarded a number of grants (R25) for CAM curricula development as part of their CAM Education Project Grant. In light of the variety of curricular activities, Berman advised, "...some general consensus needs to be reached on the essentials of a core curriculum. This should aim to improve doctors' knowledge of complementary and alternative therapy practices and their place in patient care; their ability to advice and guide patients about these therapies; their ability to refer patients to practitioners of complementary and alternative therapy; and their knowledge of the practicalities of such as credentials and legal and reimbursement issues" (BMJ 2001;322:121-122).

Although the Society of Teachers of Family Medicine has published suggested curriculum guidelines on CAM and recommended CAM knowledge, skills, and attitudes for incorporation into family practice residency training (Fam Med 1999;31:30-33), there

are very few postgraduate CAM training opportunities for conventional health care providers. Because postgraduate programs such as University of Arizona's two-year Fellowship in Integrative Medicine are limited to four fellows per year, the University of Arizona created an Associate Fellowship to expand the availability of training in integrative medicine (Susan E. South, MA, WHCCAMP Testimony 22 Feb 01). Other postgraduate training opportunities are evolving such as New York's Beth Israel Medical Center The Continuum Center for Health & Healing which has developed a family medicine residency required rotation in integrative medicine as well as a 2-year-fellowship in integrative medicine (Woodson C. Merrell, MD, WHCCAMP Testimony 5 Dec 00). The number of postgraduate training opportunities is small relative to those for continuing education. But much of the continuing education consists of learning about CAM rather than the acquisition of CAM skills. There appear to be more CAM educational opportunities for physicians than for other conventional health care professionals.

Challenges: The challenges include professional, organizational, and institutional resistance; funding; providing adequate incentives to adopt these curricula; numerous logistical design, development, and implementation issues; achieving consensus of curricula; availability of adequately trained faculty and faculty development; and limited ability to make any addition to very full curricula.

Draft Recommendations:

8. A basic curriculum which surveys the CAM modalities and ensures basic skills in collaborating with or supervising CAM professional is recommended for conventional health care professionals in professional schools, postgraduate training programs, and continuing education programs to increase knowledge and understanding of CAM in order to enhance and protect the public's health.

9. Curricula in CAM fundamentals and principles should be developed at conventional health care professional schools in conjunction with CAM experts and CAM institutions.

10. Conventional health care providers interested in practicing a CAM modality or system of healing should obtain the necessary education in postgraduate or continuing education programs or at accredited CAM institutions.

Issue 7. Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers.

Background: Making available postgraduate and continuing education for CAM practitioners resembling that of conventional health care providers was suggested to enhance the competency of CAM practitioners and quality of CAM provided. Postgraduate training has relevance to physicians such as naturopathic and ayurvedic physicians, particularly as these type of physicians seek licensure. For example, existing naturopathic postgraduate training programs could be expanded in scope and number of participants and extended in duration for comparability with allopathic primary care residencies. Although new programs could be established, joint training with existing

allopathic or osteopathic residencies may be more feasible. Those primary care residencies affiliated with community health centers should be given special consideration for development of joint training. Postgraduate training opportunities should be available to other types of CAM practitioners as well. While new discipline-specific continuing education programs can be created, a more cost-effective approach could be to have combined or joint continuing education which could include different types of CAM practitioners and even conventional health care providers, all of whom could receive their respective continuing education credit.

The American Association of Naturopathic Physicians (AANP) provided written testimony for the 22-23 February 2001 Education and Training Meeting and stated, "There is general consensus in the naturopathic profession that requiring a minimum of level of postgraduate training for naturopathic physicians is a desired goal." In its written testimony, AANP reported that naturopathic postgraduate education has been in existence since 1979 and consists of approximately twenty, one-year programs with an emphasis on primary care family practice. While AANP described naturopathic postgraduate education as "continues to evolve," AANP further characterized it as limited by the number of available one-year residencies and lack of Federal funding. ANNP pointed out that one state, Utah, requires the completion of a one-year postgraduate program that is certified by CNME for licensure of naturopathic physicians.

In general, opportunities for continuing education for CAM practitioners also is limited. The House of Lords recognized the importance and relative non-availability of continuing education for CAM practitioners and recommended that "CAM therapies... should identify continuing professional development in practice as a core requirement for their member" (House of Lords Select Committee on Science and Technology, Sixth Report: Complementary and Alternative Medicine, 21 November 2000, Chapter 6: Professional Training and Education).

Challenges: For postgraduate training programs, the challenges include professional and institutional resistance; funding; availability of a sufficient number of training sites, patients, and faculty; and attaining consensus on the content of the training. For continuing education, the challenges include professional and organizational resistance; funding; achieving consensus on curricula, and availability of appropriate faculty.

Draft Recommendations:

11. Opportunities and funding for postgraduate and continuing education resembling that of conventional health care providers is recommended for CAM practitioners providing primary care to enhance the competency and quality of healthcare.

12. Combined or joint continuing education and residency programs which include different types of CAM practitioners and conventional health care providers are recommended to improve their mutual understanding and enhance their collaborative interaction.

List of Education and Training Draft Recommendations:

1. Appropriate access to funding and other resources for CAM faculty, curricula, and program development at accredited institutions and by licensed professions by amending Titles VII and VIII of the PHS Act to authorize Health Resources and Services Administration, Bureau of Health Professions to provide this type of funding is recommended.

2. Joint research and educational programs involving CAM practitioners and conventional practitioners should be established and financial support for these programs should be identified.

3. National educational standards for CAM modalities, therapies, and practices need to be established by professional and educational institution organizations linked with the proposed Federal CAM Coordinating Office.

4. A basic curriculum in conventional medical sciences is recommended for CAM students and practitioners to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers.

5. Encourage and fund collaboration between CAM and conventional health care institutions.

6. Traditional healers who practice within a community which provides traditions and oversight should be provided appropriate access to educational funding and allowed to continue to practice without State censure, providing:

   a. Their clients are fully informed of their training (or lack thereof)
   b. They do not mislead their clients by use of titles of licensed professions
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7. CAM students should be eligible for State and where appropriate national fiscal support based on service to designated area. Eligibility would apply to loans, loan forgiveness, and scholarships. The next reauthorization of Titles VII and VIII of the Public Service Act will be amended to include enabling legislation to make CAM students eligible.

8. A basic curriculum which surveys the CAM modalities and ensures basic skills in collaborating with or supervising CAM professional is recommended for conventional health care professionals in professional schools, postgraduate training programs, and continuing education programs to increase knowledge and understanding of CAM in order to enhance and protect the public's health.

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10. Training in the provision of CAM modalities and practices is not recommended for conventional health care professionals in professional schools.

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Issue 1. Access to funding and other resources for CAM faculty, curricula, and program development.

Background: Representatives from CAM institutions and professional and educational organizations recommended improving access to funding and other resources for CAM faculty, curricula, and program development. Theoretically, this could result primarily in better CAM education and training, better trained CAM practitioners, and better quality of CAM services. Secondarily, this may attract more CAM students and perhaps eventually increase the number of well-trained CAM practitioners. One of the ways in which this improved funding can be approached is through amending Titles VII and VIII of the PHS Act which could authorize Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr) to provide this type of funding perhaps at the expense of other programs.

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education programs are established through specific legislation in the Public Health Service Act. These programs are directed toward specific health disciplines and, as a result, we have very little leeway in how we allocate funds."

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In an editorial, Berman (BMJ 2001;322:121-122) recounted, "In 1995 a national conference on complementary and alternative therapy education involving the National Institutes of Health recommended that complementary and alternative therapy should be included in nursing and medical education." Although Wetzel et al. (JAMA 1998;280:784-787) reported that 64% of allopathic medical schools offered elective courses in CAM or included these topics in required courses, most were stand-alone CAM electives with contact time varying from 6-160 hours. Bhattacharya (J Alt Comp Med 2000;6:77-90) provided a compilation of groups with curricular initiatives; however, heterogeneity of content, format, and requirements is apparent. Recently, NIH NCCAM awarded a number of grants (R25) for CAM curricula development as part of their CAM Education Project Grant. In light of the variety of curricular activities, Berman advised, "...some general consensus needs to be reached on the essentials of a core curriculum. This should aim to improve doctors' knowledge of complementary and alternative therapy practices and their place in patient care; their ability to advice and guide patients about these therapies; their ability to refer patients to practitioners of complementary and alternative therapy; and their knowledge of the practicalities of such as credentials and legal and reimbursement issues" (BMJ 2001;322:121-122).

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are very few postgraduate CAM training opportunities for conventional health care providers. Because postgraduate programs such as University of Arizona's two-year Fellowship in Integrative Medicine are limited to four fellows per year, the University of Arizona created an Associate Fellowship to expand the availability of training in integrative medicine (Susan E. South, MA, WHCCAMP Testimony 22 Feb 01). Other postgraduate training opportunities are evolving such as New York's Beth Israel Medical Center The Continuum Center for Health & Healing which has developed a family medicine residency required rotation in integrative medicine as well as a 2-year-fellowship in integrative medicine (Woodson C. Merrell, MD, WHCCAMP Testimony 5 Dec 00). The number of postgraduate training opportunities is small relative to those for continuing education. But much of the continuing education consists of learning about CAM rather than the acquisition of CAM skills. There appear to be more CAM educational opportunities for physicians than for other conventional health care professionals.

Challenges: The challenges include professional, organizational, and institutional resistance; funding; providing adequate incentives to adopt these curricula; numerous logistical design, development, and implementation issues; achieving consensus of curricula; availability of adequately trained faculty and faculty development; and limited ability to make any addition to very full curricula.

Draft Recommendations:

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Issue 7. Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers.

Background: Making available postgraduate and continuing education for CAM practitioners resembling that of conventional health care providers was suggested to enhance the competency of CAM practitioners and quality of CAM provided. Postgraduate training has relevance to physicians such as naturopathic and ayurvedic physicians, particularly as these type of physicians seek licensure. For example, existing naturopathic postgraduate training programs could be expanded in scope and number of participants and extended in duration for comparability with allopathic primary care residencies. Although new programs could be established, joint training with existing

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In general, opportunities for continuing education for CAM practitioners also is limited. The House of Lords recognized the importance and relative non-availability of continuing education for CAM practitioners and recommended that "CAM therapies... should identify continuing professional development in practice as a core requirement for their member" (House of Lords Select Committee on Science and Technology, Sixth Report: Complementary and Alternative Medicine, 21 November 2000, Chapter 6: Professional Training and Education).

Challenges: For postgraduate training programs, the challenges include professional and institutional resistance; funding; availability of a sufficient number of training sites, patients, and faculty; and attaining consensus on the content of the training. For continuing education, the challenges include professional and organizational resistance; funding; achieving consensus on curricula, and availability of appropriate faculty.

Draft Recommendations:

11. Opportunities and funding for postgraduate and continuing education programs resembling ~~that~~ of conventional health care providers is recommended for CAM practitioners providing primary care to enhance the competency and quality of healthcare.

12. Combined or joint continuing education and residency programs which include different types of CAM practitioners and conventional health care providers are recommended to improve their mutual understanding and enhance their collaborative interaction.

List of Education and Training Draft Recommendations:

1. Appropriate access to funding and other resources for CAM faculty, curricula, and program development at accredited institutions and by licensed professions by amending Titles VII and VIII of the PHS Act to authorize Health Resources and Services Administration, Bureau of Health Professions to provide this type of funding is recommended.

2. Joint research and educational programs involving CAM practitioners and conventional practitioners should be established and financial support for these programs should be identified.

3. National educational standards for CAM modalities, therapies, and practices need to be established by professional and educational institution organizations linked with the proposed Federal CAM Coordinating Office.

4. A basic curriculum in conventional medical sciences is recommended for CAM students and practitioners to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers.

5. Encourage and fund collaboration between CAM and conventional health care institutions.

6. Traditional healers who practice within a community which provides traditions and oversight should be provided appropriate access to educational funding and allowed to continue to practice without State censure, providing:

   a. Their clients are fully informed of their training (or lack thereof)
   b. They do not mislead their clients by use of titles of licensed professions
   c. They have not been censured by their community.

7. CAM students should be eligible for State and where appropriate national fiscal support based on service to designated area. Eligibility would apply to loans, loan forgiveness, and scholarships. The next reauthorization of Titles VII and VIII of the Public Service Act will be amended to include enabling legislation to make CAM students eligible.

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- Issues should be based on an identified & substantiated problem, not just testimony (testimony identifies potential issues - we need to validate them)
- Delete all the chatty quotes - use published data whenever possible or testimony that provides data (not opinions). All should be footnoted.

«Education and Training of Health Care Practitioners in CAM»

- Delete references to CAM central

Staff Lead: Joe Kaczmarczyk
Members: George Bernier (Facilitator), Joe Pizzorno (Facilitator), David Bresler, Joe Fins, Buford Rolin, and Donald Warren

Summary of Education and Training Issues:

- Access to funding and other resources for CAM faculty, curricula, and program development
- National educational standards to practice CAM
- Basic or core conventional health curriculum for CAM students and practitioners
- "Traditional Healing" education and training
- Participation of CAM students in scholarship and loan programs
- Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels
- Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers

There is no documentation that this is a problem. Need some hard stats.

Issue 1. Access to funding and other resources for CAM faculty, curricula, and program development.

Background: Representatives from CAM institutions and professional and educational organizations recommended improving access to funding and other resources for CAM faculty, curricula, and program development. Theoretically, this could result primarily in better CAM education and training, better trained CAM practitioners, and better quality of CAM services. Secondarily, this may attract more CAM students and perhaps eventually increase the number of well-trained CAM practitioners. One of the ways in which this improved funding can be approached is through amending Titles VII and VIII of the PHS Act which could authorize Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr) to provide this type of funding perhaps at the expense of other programs.

So what? Did others apply?

During FY2000, NCCAM awarded research grants to Bastyr University, Maharishi University of Management, and Palmer College of Chiropractic. ~~The majority of support~~ from NCCAM was given to conventional institutions. ~~According to testimony provided on February 22, 2001 by Mr. Neal Sampson, Deputy Associate Administrator~~, HRSA's ~~Bureau of Health Professions,~~ "The Bureau of Health Professions' ~~involvement in~~ training and education ~~programs on CAM, at this point, is very limited~~. ~~The Bureau~~'s Division of Nursing currently funds three graduate programs that include content on complementary and alternative therapies. And BHPr funds the Chiropractic Demonstration Project Grants Program, which supports research projects where chiropractors and physicians collaborate to identify and provide effective treatment for spinal and lower-back conditions. Currently, research is the only activity legislatively authorized under this program.. ~~All of the Bureau's Title VII and VIII training and~~

education programs are established through specific legislation in the Public Health Service Act. These programs are directed toward specific health disciplines and, as a result, we have very little leeway in how we allocate funds."

Challenges: The challenges include availability of funding in an era of diminishing resources and increased competition for all available resources, conventional health professions organizational and institutional resistance, equitable identification and prioritization of CAM recipients of increased funding, and ultimately the need for Federal legislation and appropriations.

Draft Recommendations:

1. Appropriate access to funding and other resources for CAM faculty, curricula, and program development at accredited institutions and by licensed professions by amending Titles VII and VIII of the PHS Act to authorize Health Resources and Services Administration, Bureau of Health Professions to provide this type of funding is recommended.

2. Joint research and educational programs involving CAM practitioners and conventional practitioners should be established and financial support for these programs should be identified. — This does not address the issue + requires some explanation of what's meant by research + ed. programs

Issue 2. National Educational Standards to Practice CAM.

Background: On February 22, 2001, during the WHCCAMP meeting on Education and Training, the Commissioners in Discussion Group #4 indicated that there should be national educational standards for CAM modalities, therapies, and practices established by professional and educational institution organizations linked with the proposed Federal CAM coordinating office. They also expressed that these standards should include exposure to not only a variety of commonly utilized CAM modalities, therapies, and practices, but also conventional health care. In addition, these Commissioners endorsed creating a professional role for RNs, LCSWs, and others as a "Care Navigator," as envisioned by Richard Miles in his testimony, to listen and coach consumer on referral in a manner that preserves consumer choice and safety.

Why? What's the problem, how would this be of benefit?

This is not in the purview of the commission

Despite the large number of practices, therapies, modalities, disciplines, and professions involved which make this an exceedingly complex issue, the House of Lords Select Committee on Science and Technology (Sixth Report: Complementary and Alternative Medicine, 21 November 2000, Chapter 6: Professional Training and Education) stated: "We recommend that CAM training courses should become more standardized and be accredited and validated by the appropriate professional bodies. All those who deliver CAM treatments, whether conventional health professionals or CAM professionals, should have received training in that discipline independently accredited by the appropriate regulatory body." They went on to say, " This would protect the public who use CAM and would improve the transparency of the organizations and make understanding what practitioners' qualifications mean easier. It is clear to us that the quality and degree of standardization of training within each therapy are closely linked to

What's the link betw the UK + the US? Why is their recommend. valid to us?

how successful each individual therapy has been in overcoming internal divisions and coming together under the auspices of a single body that agrees core objectives for education and regulation."

Challenges: The challenges include similarity to licensure and perceived encroachment on States' rights, degree of complexity, ~~multiple contentious issues~~, funding requirements, need for legislation and appropriations, questionable authority, and ~~widespread resistance~~.

Draft Recommendation:

3. National educational standards for CAM modalities, therapies, and practices need to be established by professional and educational institution organizations ~~linked with the proposed Federal CAM Coordinating Office~~.

combine w/ #2

Issue 3. Basic or core conventional health care ~~health care~~ curriculum for CAM students and practitioners.

Background: A basic or core curriculum for CAM students and practitioners was suggested to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers. This core curriculum should include information on an evidence-based approach to health care (including specific training in critiquing CAM trials), conventional health care (including referral to conventional health care providers), and other CAM modalities and systems of heath care. By learning about other CAM modalities and systems of care, CAM students and practitioners could learn how and when to refer to other CAM practitioners.

After acknowledging a deficiency in CAM training for allopathic students, Caspi et al. (Arch Intern Med 2000;160:3193-3195) asserted that there "should be a perfectly symmetrical process, ie, that the depth and breadth of the training of CAM practitioners should be such that they would be able to speak the biomedical language." These authors expressed concern about lack of exposure of CAM students "to allopathy and its related sciences."

use a different word →

Challenges: The challenges include professional, organizational, and institutional ~~resistance~~; funding; providing adequate incentives to adopt these curricula; ~~numerous~~ logistical design, development, and implementation issues; achieving consensus of curricula; availability of adequately trained faculty and faculty development; and ability to make any addition to very full curricula.

what does this mean?

Draft Recommendations:

4. A basic curriculum in conventional health care and medical sciences is ~~recommended~~ for CAM students and practitioners to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers.

This is under the purview of organizations that accredit the schools

5. Encourage and fund collaboration between CAM and conventional health care institutions.

Issue 4. Traditional Healing Education and Training.

Background: Since traditional healing falls under the rubric of CAM, numerous questions are possible. For example, who should be allowed to use the title "Traditional Healer" and what education and training are necessary to be designated a "Traditional Healer?" In addition, to whom should traditional healing and other culturally-based healing practices be taught? Should they be reserved only for members of the culture of origin or should they be taught to anyone? How should traditional healing be taught? These questions have relevance to the Indian Health Service and Health Resources and Services Administration's Bureau of Primary Health Care.

Input from the Association of American Indian Physicians, Dine [Navajo] Medicine Association Inc., Papa Ola Lokahi, and Native Hawaiian healer Kawaikapuokalani Hewett was solicited and received for the February 22-23, 2001 meeting on Education and Training. Input also was received from Alaskan Natives after the February meeting. The aggregate input from American Indians, Native Hawaiians, and Alaskan Native supported continued application and practice of their traditions for designation, selection, education and training, self-regulation, and licensure exemption of Traditional Healers.

Challenges: The challenges include the definition of "Traditional Healing" and "Traditional Healer," funding, cultural sensitivity, questionable authority in this area, and wide-spread resistance to any outside intervention.

Draft Recommendation:

Traditional healers ~~who practice within a community which provides traditions and oversight should be provided appropriate access to educational funding and~~ are allowed to continue to practice without State censure, providing:

a. Their clients are fully informed of their training (or lack thereof)
b. They do not mislead their clients by use of titles of licensed professions
c. They have not been censured by their community.

Issue 5. Participation of CAM Students in Scholarship and Loan Programs.

Background: Participation in scholarship and loan programs was suggested by CAM students and representatives from CAM institutions and CAM professional organizations. This implies participation in Federal programs such as the National Health Service Corps (NHSC) scholarship and loan forgiveness programs. Recently, NHSC was relocated within HRSA by moving it from the Bureau of Primary Health Care (BPHC) to the Bureau of Health Professions (BHPr). Participation in NHSC scholarship and loan forgiveness programs is defined in authorizing legislation (PHS Act, Title III, Section 301) which is interpreted narrowly by NHSC. In other words, unless a health profession

- Schlorships + loans are made + are available thru financial institutions + are avail. to students in accredited schools.
- Loan repayment + NHSC scholarships are different + not approp.

is specifically named in authorizing legislation, members of that health profession cannot participate in NHSC programs.

NHSC meets approximately 12-15% of its need through exclusive participation of conventional health care providers. There is no CAM participation in NHSC programs at this time. Discussions with NHSC indicated that their preference is for loan forgiveness programs, because it is considerably easier for NHSC to match a fully trained provider through loan a forgiveness program than it is through a scholarship program.

The likelihood of CAM participation in NHSC programs is low for a number of reasons. First, NHSC meets such a small percentage of its need with conventional providers that there is a greater need for conventional health care providers than CAM practitioners. Second, legislation would have to delineate which CAM disciplines and practitioners would be eligible to participate in Federal programs. Third, there would need to be additional appropriations to fund CAM practitioner participation in these programs. Fourth, while there are guidelines for determining the number of a given type of conventional health care practitioner for a defined population size or geographic area, no such guidelines exist for CAM practitioners. In short, a more likely scenario would be CAM student and practitioner participation in State-funded programs.

Currently, there is a Senate--but not an accompanying House—draft NHSC reauthorization bill which includes chiropractors in a three-year demonstration. However, neither NHSC nor BHPr has conducted any type of financial analysis of the impact of inclusion of CAM students and practitioners in Federal scholarship and loan programs. Meanwhile, the most recent NHSC data indicate decreasing ability to meet identified need, meeting only 10% of the identified need in terms of conventional providers. NHSC expects to award only 300 new scholarships this year, while approximately 800 providers leave medically underserved areas per year. There are approximately 70 State programs not affiliated with NHSC.

Challenges: The challenges include preference for conventional health care providers to fill the largely unmet need, requirement for legislative and appropriations changes, identification of specific CAM disciplines and practitioners, and difficulty in administering CAM–inclusive programs particularly in the absence of population and geographic guidelines for CAM practitioners and financial impact data.

Draft Recommendation:

7. CAM students should be eligible for State and where appropriate national fiscal support based on service to designated areas. Eligibility would apply to loans, loan forgiveness, and scholarships. The next reauthorization of Titles VII and VIII of the Public Service Act should be amended to include enabling legislation making CAM students eligible.

Issue 6. Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.

Background: A basic or core CAM curriculum for conventional health care professionals in professional schools, postgraduate training programs, and continuing education programs ~~was suggested to~~ increase knowledge and understanding of CAM in order to enhance and protect the public's health. These curricula in CAM fundamentals and principles should be developed in conjunction with CAM experts and CAM institutions. These curricula should establish, to the extent possible, an evidence-based foundation for conventional health professionals to discuss CAM use with their patients, to make referrals to appropriately trained CAM professionals, and to develop an understanding of the interactions, either therapeutic or harmful, between conventional and CAM treatments to improve and safeguard their patients' health. The conventional health care professions for whom these curricula should be developed should include, but not be limited to, allopathic and osteopathic physicians, physician assistants, nurses, dentists, pharmacists, dieticians, psychologists, social workers, physical therapists, optometrists, and podiatrists.

This does not address the needs of those conventional health care professions students and providers who desire an "integrative" approach and wish to go beyond learning *about* CAM and learn *how* to provide CAM which is more appropriate in postgraduate and continuing education. However, impediments to doing so exist in the form of difficulty with or denial of approval of conventional residencies and continuing education programs which provide an opportunity for acquisition of CAM skills.

~~In an editorial, Berman (BMJ 2001;322:121-122) recounted, "In 1995 a national conference on complementary and alternative therapy education involving the National Institutes of Health recommended that complementary and alternative therapy should be included in nursing and medical education.~~" Although Wetzel et al. (JAMA 1998;280:784-787) reported that 64% of allopathic medical schools offered elective courses in CAM or included these topics in required courses, most were stand-alone CAM electives with contact time varying from 6-160 hours. Bhattacharya (J Alt Comp Med 2000;6:77-90) provided a compilation of groups with curricular initiatives; however, heterogeneity of content, format, and requirements is apparent. Recently, NIH NCCAM awarded a number of grants (R25) for CAM curricula development as part of their CAM Education Project Grant. In light of the variety of curricular activities, ~~Berman advised,~~ "...some general consensus needs to be reached on the essentials of a core curriculum. This should aim to improve doctors' knowledge of complementary and alternative therapy practices and their place in patient care; their ability to advice and guide patients about these therapies; their ability to refer patients to practitioners of complementary and alternative therapy; and their knowledge of the practicalities of such as credentials and legal and reimbursement issues" (BMJ 2001;322:121-122).

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Sounds like a curriculum already exists & could be a model for others.

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Groft, Stephen (WHCCAMP)

From: Kaczmarczyk, Joseph (WHCCAMP)
Sent: Wednesday, August 22, 2001 3:05 PM
To: Buford Rolin; David Bresler; Donald Warren; George Bernier (E-mail); Joe Fins; Joe Pizzorno; Louise Johnson
Cc: Axelrod, Corinne (WHCCAMP); Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Jim Gordon (E-mail); Jim Swyers (E-mail); Kingsbury, Doris (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP)
Subject: 24 Aug 01 Conference Call

Importance: High

22 Aug 01

Members of the Education and Training Work Group,

I've attached two files--MS Word and rich text--containing a proposed agenda and information for discussion for our conference call scheduled for Friday, 24 August 2001, 12:00-2:00 PM (EST). I also cut and pasted the text below.

I will be out of the office until Friday at 8:00 AM (EST).

Thank you,
Joe

Proposed Agenda for Education ...

Proposed Agenda for Education ...

Proposed Agenda for Education and Training Conference Call #2
Scheduled for 24 August 2001

Overview:

1. Receipt of summary of first conference call (16 August 2001)
2. Results of rank ordering issues
3. Identification of any other issues
   a. Financial impact of scholarship and loan programs (Jim Gordon)
4. Delineation (list) of issues with agreement to formulate draft recommendations
5. Summary of draft recommendations received
6. Delineation (list) of unresolved issues (i.e., no agreement to formulate draft recommendations)
7. Discussion of unresolved issues
8. Determination of next steps

Results of Rank Ordering Issues:

1. Issue 4. Access to funding and other resources for CAM faculty, curricula, and program development.

2. Issue 6. National Educational Standards to Practice CAM.
3. Issue 2. Basic or core conventional health care health care curriculum for CAM students and practitioners.
4. Issue 7. Traditional healing education and training.
5. Issue 5. Participation of CAM Students in Scholarship and Loan Programs.
6. Issue 1. Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.
7. Issue 3. Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers.

Identification of Any Other Issues:
In a meeting on 20 August 2001, Dr. Jim Gordon asked if the financial impact of including CAM students in scholarship and loan programs had been discussed by the Work Group and recommended that it hadn't, it should be discussed by the Work Group.

List of Issues with Agreement to Formulate Draft Recommendations:

- **Issue 1.** Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.
- **Issue 2.** Basic or core conventional health care health care curriculum for CAM students and practitioners.
- **Issue 3.** Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers.

Summary of Draft Recommendations Received:
Issue 1. Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.

Draft Recommendations:

1. A basic curriculum which surveys the CAM professions and ensures basic skills in collaborating with or supervising CAM professional is recommended for conventional health care professionals in professional schools, postgraduate training programs, and continuing education programs to increase knowledge and understanding of CAM in order to enhance and protect the public's health.
2. Training in the provision of CAM modalities and practices is not recommended for conventional health care professionals in professional schools.
3. Curricula in CAM fundamentals and principles should be developed in conjunction with CAM experts from CAM institutions.

Issue 2. Basic or core conventional health care health care curriculum for CAM students and practitioners.

"The development of a basic or core curriculum for CAM students and practitioners is the third issue that I wish to comment integration versus total autonomy for faculty that will probably be decided, at least upon. I find this relatively non-contentious except for the issue of CAM in the beginning, on an ad-hoc basis... The educational process should provide experiences for CAM students in adverse event reporting and in evidence-based approaches to health care."

Draft Recommendations:

1. A basic curriculum in conventional medical sciences is recommended for CAM students and practitioners to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers.
2. Encourage and fund collaboration between CAM and CM institutions.

Issue 3. Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers.

Draft Recommendations:

1. Opportunities and funding for postgraduate and continuing education resembling that of conventional health care providers is recommended for CAM practitioners providing primary care to enhance the competency and quality of healthcare.
2. Combined or joint continuing education and residency programs which include different types of CAM practitioners and conventional health care providers are recommended to improve their understanding of each other and ability to collaborate.

Issue 4. Access to funding and other resources for CAM faculty, curricula, and program development.

"The biggest issue I perceive in the educational section is access to funding for CAM faculty, curriculum, and programs. While supportive of the efforts of CAM investigators to develop research programs, there is concern that 'leveling the playing field' will be viewed as supporting a lower grade of research and education. This problem may potentially be handled in a win-win way."

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1. Appropriate access to funding and other resources for CAM faculty, curricula, and program at accredited institutions and licensed professions is recommended.
2. Amend Titles VII and VIII of the PHS Act to authorize Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr) to provide this type of funding.
3. Joint research and educational programs involving CAM practitioners and conventional practitioners should be established and financial support for these programs be identified.

> "Rationale: The number of research-oriented CAM practitioners is small compared to the number of research-oriented conventional practitioners. This recommendation would provide the opportunity for development of a cadre of research-educators to become the nucleus of research and education programs."

Issue 5. Participation of CAM Students in Scholarship and Loan Programs.

Draft Recommendations:

1. CAM students and representatives from CAM institutions and CAM professional organizations should be eligible for participation in scholarship, loans and loan forgiveness programs such as currently available to conventional practitioners.
2. Authorize the National Health Service Corps (NHSC) to include licensed CAM practitioners in scholarship and loan forgiveness programs.

Issue 6. National Educational Standards to Practice CAM.

"This issue.... has the potential to become one of the most contentious problems to emerge. This is one issue that will require involvement of the state boards and recommendations are outside the scope of this commissioner group."

Draft Recommendations:

1. National educational standards for CAM modalities, therapies, and practices need to be established by professional and educational institution organizations linked with the proposed Federal CAM coordinating entity.

Issue 7. Traditional healing education and training.

Draft Recommendations:

1. Traditional healers who practice within a community which provides traditions and oversight should be provided appropriate access to educational funding and allowed to continue to practice without state censure, providing:
    a. Their clients are fully informed of their training (or lack thereof)
    b. They do not mislead their clients by use of titles of licensed professions
    c. They have not been sanctioned by their community.

List of Unresolved Issues (i.e., no agreement to formulate draft recommendations):

- **Issue 4.** Access to funding and other resources for CAM faculty, curricula, and program development.
- **Issue 5.** Participation of CAM students in scholarship and loan Programs.
- **Issue 6.** National educational standards to practice CAM.
- **Issue 7.** Traditional healing education and training.

Groft, Stephen (WHCCAMP)

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From: Kaczmarczyk, Joseph (WHCCAMP)
Sent: Monday, August 27, 2001 4:39 PM
To: Buford Rolin; David Bresler; Donald Warren; George Bernier (E-mail); Joe Fins; Joe Pizzorno; Louise Johnson
Cc: Axelrod, Corinne (WHCCAMP); Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Jim Gordon (E-mail); Jim Swyers (E-mail); Kingsbury, Doris (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP)
Subject: Summary of Education and Training Conference Call #2 (24 Aug 01)

Importance: High

27 August 2001

Members of the Education and Training Health Care Practitioners in CAM Work Group,

I've attached the summary of our second conference call (24 August 2001) as MS Word and Rich Text Format files. Please call me at 301.435.6197 if you have any difficulty opening these files.

In addition, I've incorporated the text of the summary in this e-mail message. Please see below.

Thank you,
Joe

Summary Education and Training...

Summary Training Work Group

Summary of Education and Training Health Care Practitioners in CAM Work Group Conference Call # 2
24 August 2001

Present: Joe Pizzorno (Co-Facilitator), George Bernier, (Co-Facilitator), Donald Warren, David Bresler, Joe Fins, Steve Groft, and Joe Kaczmarczyk (Staff Lead).
Absent: Buford Rolan.

Following an initial survey of status of various documents disseminated to the Work Group, Joe Pizzorno began an issue-by-issue discussion by saying that he didn't think that it served a useful purpose to rank order the issues. Although some of the members of the work group agreed with Joe Pizzorno, Joe Kaczmarczyk pointed out that rank ordering to achieve prioritization was discussed in this mornings staff meeting and asked Steve Groft to address the purpose of prioritization. Steve Groft explained that prioritization of issues is necessary for planning and future interactions with the Administration, Congress, and media.

Issue 1. Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.

Draft Recommendations:

1. A basic curriculum which surveys the CAM professions and ensures basic skills in collaborating with or supervising CAM professional is recommended for conventional health care professionals in professional schools, postgraduate training programs, and continuing education programs to increase knowledge and understanding of CAM in order to enhance and protect the public's health.
2. Training in the provision of CAM modalities and practices is not recommended for conventional health care professionals in professional schools.
3. Curricula in CAM fundamentals and principles should be developed in conjunction with CAM experts from CAM institutions.

Joe Fins asked that "conventional health professions schools" be added to the third draft recommendation so it would read: Curricula in CAM fundamentals and principles should be developed ***at conventional health professions schools*** in conjunction with CAM experts from CAM institutions. He also requested that health professions be defined (e.g., medical, nursing, dental, pharmacy, etc.) and allied professions should be included as well. Joe Fins agreed with the assertion that this--or any other--curricular recommendation should not be a mandate. Rather, it should "strongly encourage."

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Donald Warren related that he had spoken with several people who advocated for incremental implementation of the proposed curriculum and reiterated his view that this conventional health care curriculum for CAM student should include biochemistry, physiology, anatomy, pathology, immunology, and pharmacology (including adverse event reporting) to yield a common language. Joe Fins recommended using the taxonomy from the discussion on licensure which took place earlier today in the Access and Delivery Work Group's conference call and delineated two kinds of core competencies: (1) basic science foundation; (2) physical exam and clinical skills. Joe Fins
said that what is needed is essentially "requisite basic information for collaboration and referral" and proposed using the Physician Assistant (PA) 2-year curriculum as a model for incorporating conventional health care in CAM education programs. Joe Kaczmarczyk responded by emphasizing both curricular draft recommendations (Issues #1 and #2) are intended to allow students to become conversant with practitioners and patients to achieve bilateral communication. Joe Pizzorno interjected that these draft curricular recommendations are about a CAM survey for conventional health care student and providers and increased competencies for CAM students and practitioners. George Bernier opined that because of how dissimilar PA and CAM curricula are, "avoid linking PA and CAM curricula." Joe Pizzorno added, "CAM education would benefit from more conventional medicine."

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Joe Fins initiated discussion of these draft recommendations by suggesting language such as "expand postgraduate and continuing education for CAM practitioners including further development of residency programs... appropriate for persons with doctoral degrees and collaboration with allopathic programs." George Bernier asked Joe Pizzorno about the relative number of postgraduate training opportunities available to naturopathic physicians. Joe Pizzorno indicated, "15-20% of NDs have opportunities for residencies" and cited the example of Utah which requires a one-year residency for ND licensure. George Bernier then asked for clarification of who would provide accreditation of CE material. Joe Pizzorno rejoined that it should be "defined by State licensing boards." Joe Fins asserted, "Make CE a separate issue and recommendation... with demonstration projects and dissemination of models." Joe Pizzorno disagreed, "I don't think we need to recommend CE." Joe Kaczmarczyk countered that CE should be recommended, because of unlicensed CAM practitioners who would not have State-mandated CE for licensure renewal. Joe Fins captured the essence of the discussion with his summary admonition that practitioners need to "assume the responsibility to stay current."

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> "Rationale: The number of research-oriented CAM practitioners is small compared to the number of research-oriented conventional practitioners. This recommendation would provide the opportunity for development of a cadre of research-educators to become the nucleus of research and education programs."

George Bernier articulated his concern about "leveling the playing field" which may lead to the perception of lowering the grade of research and education. David Bresler asked about "why should money be diverted from proven..." programs and processes and recapitulated Joe Fins' concerns from the Work Group's first conference call. Joe Fins agreed with David. David went on to describe the Small Business Administration's SBIR program which seeks innovations in research and questioned, "Why couldn't education be approached in the same way for both CAM and conventional?" Steve Groft very briefly reviewed the SBIR requirements at NIH. In response to the SBIR discussion, Joe Fins said, " Encourage CAM-related activities." David Bresler suggested tax credits or low-interest loans as incentives to engage the private sector and spoke of CAM education as a new cottage industry. Joe Fins expressed his view that this approach was more applicable to research and device or product development. David Bresler gave an example of conventional health curricula for CAM students and practitioners which could be developed with this type of approach. Joe Fins recommended emulating models from minority institutions to build infrastructure for CAM institutions. George Bernier inquired about Joe Fins' comment from the first conference call. Joe Fins answered, "Encourage RFPs that produce collaboration." Joe Pizzorno asked, "Are we adding the fourth recommendation per David?" [Silence.]

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1. CAM students and representatives from CAM institutions and CAM professional organizations should be eligible for participation in scholarship, loans and loan forgiveness programs such as currently available to conventional practitioners.
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Joe Pizzorno stated that "students at accredited institutions should be eligible" for participation in these programs. Donald Warren responded, "Loan forgiveness is problematic... for whom... for which geographic areas?" Joe Pizzorno described the State of Washington's program in which communities must request a CAM practitioner and that practitioner must be licensed. Joe Kaczmarczyk reviewed much of the relevant material that was in the "straw man" document and explained why he would recommend exploring the possibility of participation in State rather than Federal programs. After a dialogue between Joe Pizzorno and Joe Kaczmarczyk, Joe Pizzorno asked George Bernier to re-write the draft recommendations... to encourage State loan forgiveness program for CAM student and practitioners.

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When George Bernier solicited comments on this draft recommendation, Joe Pizzorno suggested changing "***National Standards for CAM Education***." Subsequently, the Work Group decided to revisit this issue and draft recommendation when Joe Fins returned to the conference call after a brief hiatus.

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Joe Pizzorno reiterated Buford Rolin's example of an non-Native American man who, after being married to a Navajo woman for a number of years and then divorcing her, proclaimed himself a Navajo Traditional healer in New York City. Donald Warren said that this individual would not be reported to the New York Medical Board for practicing without a license. Joe Pizzorno related that the "Minnesota law," according to Native Americans, had no input from Native Americans. Joe Kaczmarczyk asked for clarification of the usage of the word "sanctioned" which, after discussion, was replaced by the word ***censured***.

The discussion returned to issue #6 with the suggestion that the proposed Federal CAM Coordinating Office should be responsible for developing a consensus plan for educational standards consistent with professional standards for licensure where appropriate (e.g., diagnosis and treatment) and otherwise registration and certification where licensure is not appropriate. Joe Pizzorno reiterated that the issue should be restated as "***National Standards for CAM Education***." Joe Kaczmarczyk raised the question about what happens when a given modality is shared by many disciplines. Joe Pizzorno answered, "Differentiate modality from profession."

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Joe Kaczmarczyk asked that the revised draft recommendations be e-mailed to him, so he could incorporate them in the next iteration of the education and training document which will be e-mailed to the Work Group. When Joe Kaczmarczyk asked about another conference call, he was told by the Work Group to wait and see if one is needed and rely on e-mail to do any necessary wordsmithing.

Respectfully submitted on 27 August 2001 by,
Joseph M. Kaczmarczyk, DO, MPH
Senior Medical Advisor
White House Commission on Complementary and Alternative Medicine Policy

Summary of Education and Training Health Care Practitioners in CAM Work Group Conference Call #2 24 August 2001

Present: Joe Pizzorno (Co-Facilitator), George Bernier, (Co-Facilitator), Donald Warren, David Bresler, Joe Fins, Steve Groft, and Joe Kaczmarczyk (Staff Lead).
Absent: Buford Rolan.

Following an initial survey of status of various documents disseminated to the Work Group, Joe Pizzorno began an issue-by-issue discussion by saying that he didn't think that it served a useful purpose to rank order the issues. Although some of the members of the work group agreed with Joe Pizzorno, Joe Kaczmarczyk pointed out that rank ordering to achieve prioritization was discussed in this mornings staff meeting and asked Steve Groft to address the purpose of prioritization. Steve Groft explained that prioritization of issues is necessary for planning and future interactions with the Administration, Congress, and media.

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Proposed Agenda for Education and Training Conference Call #2
Scheduled for 24 August 2001

Overview:

1. Receipt of summary of first conference call (16 August 2001)
2. Results of rank ordering issues
3. Identification of any other issues
   a. Financial impact of scholarship and loan programs (Jim Gordon)
4. Delineation (list) of issues with agreement to formulate draft recommendations
5. Summary of draft recommendations received
6. Delineation (list) of unresolved issues (i.e., no agreement to formulate draft recommendations)
7. Discussion of unresolved issues
8. Determination of next steps

Results of Rank Ordering Issues:

1. Issue 4. Access to funding and other resources for CAM faculty, curricula, and program development.
2. Issue 6. National Educational Standards to Practice CAM.
3. Issue 2. Basic or core conventional health care health care curriculum for CAM students and practitioners.
4. Issue 7. Traditional healing education and training.
5. Issue 5. Participation of CAM Students in Scholarship and Loan Programs.
6. Issue 1. Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.
7. Issue 3. Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers.

Identification of Any Other Issues:
In a meeting on 20 August 2001, Dr. Jim Gordon asked if the financial impact of including CAM students in scholarship and loan programs had been discussed by the Work Group and recommended that it hadn't, it should be discussed by the Work Group.

List of Issues with Agreement to Formulate Draft Recommendations:

- **Issue 1.** Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.
- **Issue 2.** Basic or core conventional health care health care curriculum for CAM students and practitioners.
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Summary of Draft Recommendations Received:
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to develop research programs, there is concern that 'leveling the playing field' will be viewed as supporting a lower grade of research and education. This problem may potentially be handled in a win-win way."

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    a. Their clients are fully informed of their training (or lack thereof)
    b. They do not mislead their clients by use of titles of licensed professions
    c. They have not been sanctioned by their community.

List of Unresolved Issues (i.e., no agreement to formulate draft recommendations):

- **Issue 4.** Access to funding and other resources for CAM faculty, curricula, and program development.
- **Issue 5.** Participation of CAM students in scholarship and loan Programs.
- **Issue 6.** National educational standards to practice CAM.
- **Issue 7.** Traditional healing education and training.

Summary of Education and Training Health Care Practitioners in CAM
Work Group Conference Call #1 13 August 2001

Present: George Bernier (Co-Facilitator), Joe Pizzorno (Co-Facilitator), Donald Warren, David Bresler, Buford Rolin, Joe Fins, Steve Groft, Michele Chang, and Joe Kaczmarczyk (Staff Lead).

After Joe Pizzorno described the process for the conference call, George Bernier initiated the sequential discussion of the seven issues delineated in the "straw man" document. The following is a summary of that discussion.

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Donald Warren recommended latitude in developing curricula. David Bresler asserted that decisions about curricula can be made at national meetings of organizations of the professional schools and decisions about requiring CAM in continuing education can be made at national meetings of conventional health care professions. Joe Pizzorno said that curricula should be a survey of CAM at the undergraduate level, include how to collaborate with CAM practitioners, not attempt to teach CAM skills, and be developed with CAM professionals and institutions. There was agreement that the Work Group should develop this type of draft recommendation.

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David Bresler thought that this was a contentious issue because it invoked debate about CAM integration vs. autonomy and had potential for much resistance. He suggested re-framing the issue in terms of ability to communicate and share a common language. Buford Rolin expressed concern about application and methodology of training. Joe Pizzorno and Buford Rolin engaged in a lively discussion of non-credentialed practitioners such as traditional healers many of whom, do not wish to associate with convention health care. After David Bresler asked that involved populations be addressed, Joe Pizzorno identified three populations of non-credentialed CAM practitioners: (1) those in formal educational programs, (2) those who were community-based, and (3) those who were completely independent. There was agreement that the Work Group should develop this type of draft recommendation. At the conclusion of the call, Joe Fins asked that adverse event reporting (AER) be a part of curricula for CAM students and practitioners.

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5. Joe Fins asked that adverse event reporting (AER) be included in the curricula for CAM students and practitioners.

Respectfully submitted on 15 Aug 01 by,
Joseph M. Kaczmarczyk, DO, MPH
Senior Medical Advisor, WHCCAMP

310-589-9523
Dr. Russel Breslow
6/8/13/01
12-2 PM

TOPIC: Education and Training of Health Care Practitioners
Staff Lead: Joe Kaczmarczyk
Co-Facilitators: George Bernier and Joe Pizzorno

Summary of Education and Training Issues:

- Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels
- Basic or core conventional health curriculum for CAM students and practitioners
- Postgraduate and continuing education for CAM practitioners resembling that available to conventional health care providers
- Access to funding and other resources for CAM faculty, curricula, and program development
- Participation of CAM students in scholarship and loan programs
- National educational standards to practice CAM
- "Traditional Healing" education and training

Issue 1. Basic or core CAM curriculum for conventional health care professionals at professional school, postgraduate, and continuing education levels.

Discussion: A basic or core CAM curriculum for conventional health care professionals in professional schools, postgraduate training programs, and continuing education programs was suggested to increase knowledge and understanding of CAM in order to enhance and protect the public's health. These curricula in CAM fundamentals and principles should be developed in conjunction with CAM experts. These curricula should establish, to the extent possible, an evidence-based foundation for conventional health professionals to discuss CAM use with their patients, to make referrals to appropriately trained CAM professionals, and to develop an understanding of the interactions, either therapeutic or harmful, between conventional and CAM treatments to improve and safeguard their patients' health.

This does not address the needs of those conventional health care professions students and providers who desire an "integrative" approach and wish to go beyond learning about CAM and learn how to provide CAM.

Background: To be added subsequently.

Challenges: The challenges include professional, organizational, and institutional resistance; funding; providing adequate incentives to adopt these curricula; numerous logistical design, development, and implementation issues; achieving consensus of curricula; availability of adequately trained faculty and faculty development; and ability to make any addition to very full curricula.

Draft Recommendations:

Issue 2. Basic or core conventional health care ~~health care~~/curriculum for CAM students and practitioners.

Discussion: A basic or core curriculum for CAM students and practitioners was suggested to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers. This core curriculum should include information on an evidence-based approach to health care, conventional health care, and other CAM modalities and systems of heath care. By learning about other CAM modalities and systems of care, CAM students and practitioners could learn how and when to refer to other CAM practitioners.

Background: To be added subsequently.

Challenges: The challenges include professional, organizational, and institutional resistance; funding; providing adequate incentives to adopt these curricula; numerous logistical design, development, and implementation issues; achieving consensus of curricula; availability of adequately trained faculty and faculty development; and ability to make any addition to very full curricula.

Draft Recommendations: Have a common universal language that Conventional medical practitioners

non formally credentialed healer

- Native Healers Oversight — in a Community
- Self Proclaimed healers Oversight -
- Academically Trained - Formal Training Program
- Conventional Medicator

Issue 3. Postgraduate and continuing education program for CAM practitioners resembling that ~~that~~ there available to conventional health care providers.

Discussion: Making available postgraduate and continuing education for CAM practitioners resembling that of conventional health care providers was suggested to enhance the competency of CAM practitioners and quality of CAM provided. Postgraduate training has relevance to physicians such as naturopathic and ayurvedic physicians, particularly as these type of physicians seek licensure. For example, existing naturopathic postgraduate training programs could be expanded in scope and number of participants and extended in duration. Although new programs could be established, joint training with existing allopathic or osteopathic residencies may be more feasible. Postgraduate training opportunities should be available to other types of CAM practitioners as well. While new discipline-specific continuing education programs can be created, a more cost-effective approach could be to have combined or joint continuing education which could include different types of CAM practitioners and even conventional health care providers, all of whom could receive their respective continuing education credit.

Background: To be added subsequently.

Challenges: For postgraduate training programs, the challenges include professional and institutional resistance; funding; availability of a sufficient number of training sites, patients, and faculty; and attaining consensus on the content of the training. For continuing education, the challenges include professional and organizational resistance; funding; achieving consensus on curricula, and availability of appropriate faculty.

Draft Recommendations:

Issue 4. Access to funding and other resources for CAM faculty, curricula, and program development.

Discussion: Improved access to funding and other resources for CAM faculty, curricula, and program developed was suggested by representatives from CAM institutions and professional and educational organizations to "level the playing field." Theoretically, this could result primarily in better CAM education and training, better trained CAM practitioners, and better quality of CAM services. Secondarily, this may attract more CAM students and perhaps eventually increase the number of well-trained CAM practitioners. One of the ways in which this improved funding can be approached is through amending Titles VII and VIII of the PHS Act which could authorize Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr) to provide this type of funding perhaps at the expense of other programs.

Background: To be added subsequently.

Challenges: The challenges include availability of funding in an era of diminishing resources and increased competition for all available resources, conventional health professions organizational and institutional resistance, equitable identification and prioritization of CAM recipients of increased funding, and ultimately the need for Federal legislation and appropriations.

Draft Recommendations:

need to develop parity → by good research results
need scientifically based
- demonstration projects
- Synergistic Training Programs
- Develop incentives for curriculum + Program development
- Facilitate CAM integration of effective CAM

Joe Fins → comment/Research

Mark work

Issue 5. Participation of CAM Students in Scholarship and Loan Programs.

Discussion: Participation in scholarship and loan programs was suggested by CAM students and representatives from CAM institutions and CAM professional organizations. This implies participation in Federal programs such as the National Health Service Corps (NHSC) scholarship and loan forgiveness programs. Recently, NHSC was relocated within HRSA by moving it from the Bureau of Primary Health Care (BPHC) to the Bureau of Health Professions (BHPr). Participation in NHSC scholarship and loan forgiveness programs is defined in authorizing legislation which is interpreted narrowly by NHSC. In other words, unless a health profession is specifically named in authorizing legislation, members of that health profession cannot participate in NHSC programs.

Currently, NHSC meets approximately 12-14% of its need through exclusive participation of only conventional health care providers. There is no CAM participation in NHSC programs at this time. Discussions with NHSC indicated that their preference is for loan forgiveness programs, because it is considerably easier for NHSC to match a fully trained provider through loan a forgiveness program than it is through a scholarship program.

The likelihood of CAM participation in NHSC programs is low for a number of reasons. First, NHSC meets such a small percentage of its need with conventional providers that there is a greater need for conventional health care providers than CAM practitioners. Second, legislation would have to delineate which CAM disciplines and practitioners would be eligible to participate in Federal programs. Third, there would need to be additional appropriations to fund CAM practitioner participation in these programs. Fourth, while there are guidelines for determining the number of a given type of conventional health care practitioner for a defined population size or geographic area, no such guidelines exist for CAM practitioners. In short, a more likely scenario would be CAM student and practitioner participation in State-funded programs.

Background: To be added subsequently.

Challenges: The challenges include preference for conventional health care providers to fill the largely unmet need, requirement for legislative and appropriations changes, identification of specific CAM disciplines and practitioners, and difficulty in administering CAM–inclusive programs particularly in the absence of population and geographic guidelines for CAM practitioners.

Draft Recommendations:

- Occurring in Washington state
- Data from Insurance industry on malpractice
- HRSA - Study Provision of care in these areas + practitioners
- Cannot lump all CAM practices together

Issue 6. National Educational Standards to Practice CAM.

Discussion: On February 22, 2001, during the WHCCAMP meeting on Education and Training, the Commissioners in Discussion Group #4 indicated that there should be national educational standards for CAM modalities, therapies, and practices established by professional and educational institution organizations linked with the proposed Federal CAM coordinating entity. They also expressed that these standards should include exposure to not only a variety of commonly utilized CAM modalities, therapies, and practices, but also conventional health care. In addition, these Commissioners endorsed creating a professional role for RNs, LCSWs, and others as a "Care Navigator," as envisioned by Richard Miles in his testimony, to listen and coach consumer on referral in a manner that preserves consumer choice.

The assertion that certain national educational requirements be met in order to practice a given CAM modality, therapy, or approach overlaps with licensure which has been moved from "Education and Training" into "Access and Delivery." Given the large number of modalities, disciplines, and profession involved and the complexity of this issue, it would be advisable for the WHCCAMP not to pursue this issue.

Background: To be added subsequently.

Challenges: The challenges include similarity to licensure and perceived encroachment on States' rights, mind-boggling complexity, multiple contentious issues, funding requirements, need for legislation and appropriations, questionable authority, and wide-spread resistance.

Draft Recommendations: Should they be established
- For whom
- By whom

Develop minimal standards -
established by ① Payors / Blue Cross - Blue Shield
② accrediting Boards

Issue 7. Traditional healing education and training.

Discussion: Since traditional healing falls under the rubric of CAM, numerous questions are possible. For example, who should be allowed to use the title "Traditional Healer" and what education and training are necessary to be designated a "Traditional Healer?" In addition, to whom should traditional healing and other culturally-based healing practices be taught? Should they be reserved only for members of the culture of origin or should they be taught to anyone? How should traditional healing be taught? And how should it be funded? These questions have relevance to the Indian Health Service and Health Resources and Services Administration's Bureau of Primary Health Care.

Background: To be added subsequently.

Challenges: The challenges include the definition of "Traditional Healing" and traditional Healer," funding, cultural sensitivity, questionable authority in this area, and wide-spread resistance.

Draft Recommendations:

Native Healers
Self Proclaimed
Traditional Healers Educational of Native Program

Groft, Stephen (WHCCAMP)

From: Kaczmarczyk, Joseph (WHCCAMP)
Sent: Wednesday, August 15, 2001 1:36 PM
To: Buford Rolin; David Bresler; Donald Warren; George Bernier (E-mail); Joe Fins; Joe Pizzorno; Louise Johnson; Axelrod, Corinne (WHCCAMP); Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Jim Gordon (E-mail); Jim Swyers (E-mail); Kingsbury, Doris (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP)
Subject: Summary of Education & Training 13 Aug 01 Conference Call

Importance: High

15 Aug 01

Members of Education and Training Work Group,

I've attached the summary of our 13 Aug 01 conference call as both MS Word and rich text files.
Please contact me at 301.435.6197 if you cannot open the attached files.

Also, please submit your rank-ordered draft recommendations to me by e-mail at kaczmajo@mail.nih.gov as soon as possible so we can proceed with plans for our conference call next week.

Thank you,
Joe

Summary
Training Work Group

Summary
Training Work Group

Summary of Education and Training Health Care Practitioners in CAM
Work Group Conference Call #1 13 August 2001

Present: George Bernier (Co-Facilitator), Joe Pizzorno (Co-Facilitator), Donald Warren, David Bresler, Buford Rolin, Joe Fins, Steve Groft, Michele Chang, and Joe Kaczmarczyk (Staff Lead).

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Respectfully submitted on 15 Aug 01 by,
Joseph M. Kaczmarczyk, DO, MPH
Senior Medical Advisor, WHCCAMP

Summary of Conference Call 8/13/01
Work Group B: Information Development and Dissemination

The group felt that Issue 1 was difficult, as well as broad in scope. Scott expressed some concern about a heavy focus on the Internet because many consumers do not have access to or use this form of communication. The question raised by DeVries regarding the role for government was discussed. The group is interested in pursuing the issue and draft recommendations but request more background information on which to build.

Follow-up: Bresler asked the staff to provide Group B with models of public-private partnerships and "seals of approval."

The group supported Issue 2, but agreed that a draft recommendation should be developed that placed the centralized information responsibility (clearinghouse) for CAM with a new DHHS office for CAM. Two issues were raised: how to get public input into this effort (to help assure that information is not just available at the professional/technical level but at a consumer level too), and how to link and coordinate with other federal agencies.

Follow-up: Staff will provide Group B with examples of public participation in a developing consumer-oriented information source. [Look to NCI, women and minority health initiatives, and Healthy People 2010.) Staff will provide the Group with examples of federal coordination on a health issue/initiative.

Issue 3 on privacy raised concerns among the Group. First, the issue is inherently part of broader efforts to protect privacy (this is not an issue for CAM alone), and secondly Commissioners felt they did not know enough about the issue to make specific recommendations. The Group agreed that a recommendation should be developed that addressed this more broadly, and directed the new DHHS office for CAM to coordinate with other federal agencies, monitor legislative and regulatory developments, represent CAM concerns within the Department, and assist in implementation of policy.

Follow-up: Staff will check what is happening at the federal level.

The Group agreed that Issues 4, 5, and 6 could be merged and addressed along with Issue 2 and 3 as proposed roles and responsibilities for a central (DHHS) office on CAM. Scott supported information aimed at practitioners and researchers, but also the public. She also supported school-based efforts. Generally the Group wanted more background and specificity with regard to the issues and possible recommended actions, and tabled the issue for the present.

Follow-up: Staff to provide the Group with information about what DHHS and other federal agencies are doing to address the information needs of the diverse populations, and how minority concerns may be specifically addressed.

The group wanted more information before addressing Issue 8, but raised the idea of adding this to the role and responsibilities of "CAM Central."

Follow-up: Develop the issue further.

Commissioners raised several questions regarding Issue 9. Bresler inquired whether the FTC provides any public information regarding complaints received or those under investigation. Bresler also raised for discussion the question of who should take on the responsibilities specific false and deceptive CAM claims. The Group did agree that public education regarding deceitful practices.

Follow-up: Staff should provide a couple of models of how to accomplish the proposed ideas.

Commissioners did not feel strongly about Issue 10, but agreed that it could be supported. The Group agreed that coordination with the FTC and others to protect vulnerable populations could be a role and responsibility of a central CAM office. Other ideas were to include local and/or national organizations for a public-private partnership, to utilize non-English language newspapers and community health centers as resource tools.

Follow-up: Refine and develop further.

The Commissions agreed to Issue 11 and directed staff to continue refinement of the draft recommendations.

Follow-up: Check the Minnesota law/regulations for an example/model. Continue to develop the write-up.

The Commissioners decided to table discussion of the remaining issues in the absence of Dr. Low Dog who is on jury duty.

DeVries expressed concern that the Group and the Commission move carefully with regard to recommendations involving DSHEA because he and others do not know enough about this complex area. He suggested obtaining some expert help. Julia expressed a preference for giving this section a consumer focus.

Follow-up: Staff should consult with Ken Fisher and the speaker at the July public comment period who addressed DSHEA. Consolidate issues to degree possible. Develop recommendations around the possible central CAM office and public-private partnerships.

Another call is being scheduled by Doris Kingsbury.

Clinton Presidential Records
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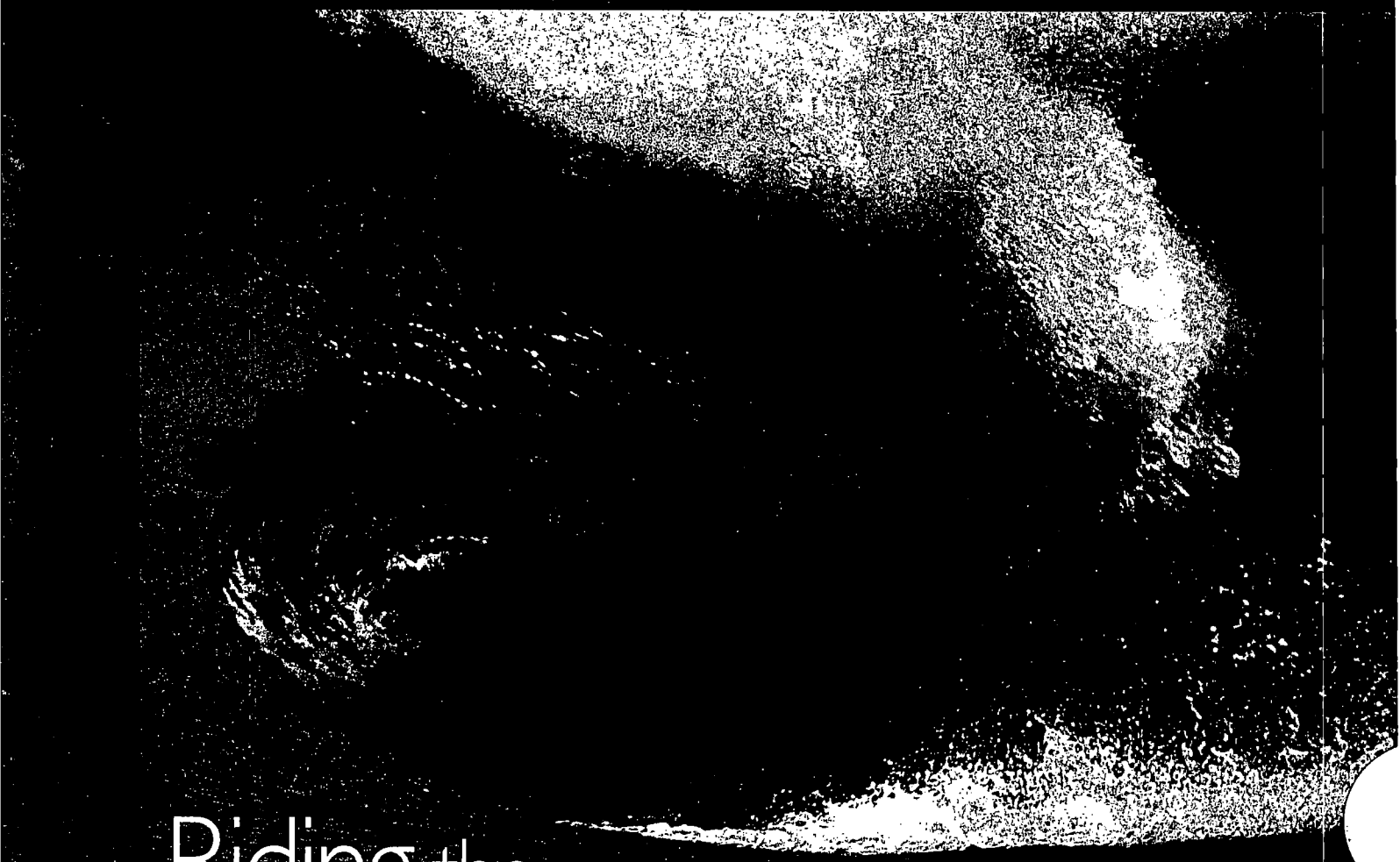
NOCA 2000 Educational Conference
and Annual Business Meeting



Riding the Credentialing Wave

Miami Beach, Florida

November 29 - December 2, 2000
Fontainebleau Hilton Hotel
Miami Beach, Florida

Kingsbury, Doris (NCCAM)

From: mbianchi@aanp.com
Sent: Tuesday, October 09, 2001 10:41 AM
To: Whccamp (NCCAM); Chang, Michele (NCCAM); Groft, Stephen (NCCAM)
Cc: traub@hawaii.rr.com
Subject: Testimony of Dr. Susan Delaney

Final--Title Practice Acts.do...

Attached and pasted below is the testimony of Dr. Susan Delaney fro the White House Commission Meeting of October 5, 2001. I had sent this to you via e-mail on September 13, 2001. Could you please make sure that the Commissioners receive this?
Thank you.
Sincerely,
Maria Bianchi
Executive Director
American Association of Naturopathic Physicians
8201 Greensboro Drive
Suite 300
McLean, Virginia 22102

Issue Statement:
One of the challenges facing the Commission is to provide guidance concerning public safety, access and freedom of choice. The problem is how to use licensing as a mechanism to protect public safety, while still ensuring freedom of choice for consumers and providers. For professions trained to diagnose, treat and prescribe substances (such as medicine, osteopathy, chiropractic, naturopathic), the answer is licensure.

There are two distinctly different types of licensing: Title Acts and Practice Acts.

Licensing by Title Acts provide the better solution to the previously mentioned problems and offer a number of advantages over Practice Acts.

Licensing by Title Acts:

1) Supports competency, high standards and public protection.

2) Provides access to services by health care professionals who diagnose and treat disease. Such health care would otherwise not be accessible to consumers, due to conflicts with the (more restrictive) medical Practice Acts.

3) Clarifies expectation in the marketplace. Defining the use of a specific title protects the public from false expectations (about service being provided by practitioners using the same title but without equivalent training).

4) Assures access by creating standardized credentials for providers for providers to be credentialed to enable providers and insurers to develop reimbursement protocols.

5) Supports health care pluralism (by fostering collaboration between a broader range of qualified providers).

For example, Title Acts for naturopathic physicians require that a person meet certain educational standards, in order to represent himself or herself as a naturopathic physician. Conversely, one may not use the title ND unless these standards are met.

IN NO WAY do Title Acts prevent others from using any of the modalities that NDs are trained to use. For example, Native American healers would not be restricted from practicing their art or profession, as long as they do not claim to be naturopathic physicians. Nor would any other practitioner be restricted by naturopathic Title Acts, from using nutritional, herbal, homeopathic or other naturopathic treatment modalities.

Licensing by Practice Acts, in contrast, are more restrictive and less inclusive.
The disadvantages of licensing by Practice Acts:
1) May create exclusive ownership to practice a modality only by those licensed under the act.
2) Can be considered protecting "turf".
3) May create conflicts and lack of cooperation.

Unless licensed under a Practice Act, all other practitioners are prohibited from using the scope regulated by that Practice Act, even if adequately trained and competent in those modalities. Unless carefully crafted and able to serve the needs of the community, historically, Practice Acts have the potential to foster conflict and a lack of cooperation in the health care system.

In conclusion, Title Acts are the appropriate solution to the challenges facing the Commission today regarding licensure. Title Acts do not alter the landscape of other providers' practice opportunities; they merely clarify the qualifications, identity and scope of practice of a particular provider. By supporting licensure through Title Acts, the Commission will meet its goals of promoting access with accountability, and supporting collaboration and freedom of choice for a broader range of qualified providers.

<<Final--Title Practice Acts.doc>>

James S. Gordon, M.D.
Chairman
The White House Commission on Complimentary and Alternative Medicine Policy
Director, The Center for Mind Body Medicine
2934 Macomb Street, NW
Washington, D.C. 20008

Dear Dr. Gordon:

It was a pleasure to meet with you briefly during the July White House Commission meeting in Washington, D.C. Here is the information that you requested of me at the meeting regarding the distinction between different types of licensure. I trust this will be helpful to you and the other commissioners and that I have met the deadline for distribution in the materials packet for the October WHC meeting. Please contact me at 203-230-2200 if I can be of any further assistance to you or the commission.

Issue Statement:
One of the challenges facing the Commission is to provide guidance concerning public safety, access and freedom of choice. The problem is how to use licensing as a mechanism to protect public safety, while still ensuring freedom of choice for consumers and providers. For professions trained to diagnose, treat and prescribe substances (such as medicine, osteopathy, chiropractic, naturopathic), the answer is licensure.

There are two distinctly different types of licensing: Title Acts and Practice Acts.

Licensing by Title Acts provide the better solution to the previously mentioned problems and offer a number of advantages over Practice Acts.

Licensing by Title Acts:

1) Supports competency, high standards and public protection.

2) Provides access to services by health care professionals who diagnose and treat disease. Such health care would otherwise not be accessible to consumers, due to conflicts with the (more restrictive) medical Practice Acts.

3) Clarifies expectation in the marketplace. Defining the use of a specific title protects the public from false expectations (about service being provided by practitioners using the same title but without equivalent training).

4) Assures access by creating standardized credentials for providers for providers to be credentialed to enable providers and insurers to develop reimbursement protocols.

5) Supports health care pluralism (by fostering collaboration between a broader range of qualified providers).

For example, Title Acts for naturopathic physicians require that a person meet certain educational standards, in order to represent himself or herself as a naturopathic physician. Conversely, one may not use the title ND unless these standards are met.

IN NO WAY do Title Acts prevent others from using any of the modalities that NDs are trained to use. For example, Native American healers would not be restricted from practicing their art or profession, as long as they do not claim to be naturopathic physicians. Nor would any other practitioner be restricted by naturopathic Title Acts, from using nutritional, herbal, homeopathic or other naturopathic treatment modalities.

Licensing by Practice Acts, in contrast, are more restrictive and less inclusive.
The disadvantages of licensing by Practice Acts:
1) May create exclusive ownership to practice a modality only by those licensed under the act.
2) Can be considered protecting "turf".
3) May create conflicts and lack of cooperation.

Unless licensed under a Practice Act, all other practitioners are prohibited from using the scope regulated by that Practice Act, even if adequately trained and competent in those modalities. Unless carefully crafted and able to serve the needs of the community, historically, Practice Acts have the potential to foster conflict and a lack of cooperation in the health care system.

In conclusion, Title Acts are the appropriate solution to the challenges facing the Commission today regarding licensure. Title Acts do not alter the landscape of other providers' practice opportunities; they merely clarify the qualifications, identity and scope of practice of a particular provider. By supporting licensure through Title Acts, the Commission will meet its goals of promoting access with accountability, and supporting collaboration and freedom of choice for a broader range of qualified providers.

Sincerely,

James Sensenig, N.D.

CC: Steve Groft, Pharm.D., E.D. WHCCAMP
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