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[Final Report Background]

2011-0568-S
kc834

RESTRICTION CODES

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Effie –
Presidential
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Effie — Feeling Responsibility

One of the most important items to move forward

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Access + Delivery

Wayne Brenza

- Sense of where we have agreement -
  Press Conference - Have agreement
- Here are areas lacking agreement -

10-12 Judge Edens

<u>The Charge for the Day and the Weeks ahead is to come to agreement on the text, recommendations, and actions that can be included in a report to the President and the Congress as stated in the Executive Order</u>

<u>Gaining Consensus –</u> We will follow a different procedure this meeting. The focus will be more on what can't you live with. We will visit each Issue and each major section of the report. You will be asked to:

- **Identify any text, action, or recommendation that you have some disagreement;**
- **State your concern briefly; and**
- **Offer your change.**
- **Can it be a simple edit, a qualifying term to be added, or is it a major issue that needs additional time either now, this evening in one-on-one discussion, or later in a telephone conference**

<u>Lack of Consensus</u> - We have talked briefly about what the Commission might be able to do if no consensus agreement can be reached on an issue, recommendation, or action.

The Commission should be guided by the need to articulate the complex and sometimes competing positions on any given issue, recommendation, or action rather than by an overriding concern to reach consensus.

The Commission may choose to proceed by offering a variety of views on a particular issue, rather than attempt to reach a single consensus position

If we reach this stage of non-agreement and are unable to address the issue adequately through textual changes, it may be necessary to

- State the situation in the report that the Commission was unable to reach agreement,

- Here are the differences of opinion, and

- Here are the options that should be considered.

- This is an acceptable action for the Commission to take.
- Those who participated in the swearing-in ceremony will recall the Secretary's request to avoid minority reports.

I think we should enter the meeting with that advice in mind and the possibility of not reaching consensus on every issue. Every situation may not be a WIN-WIN situation, but we must reach our goal of producing an acceptable report and submitting it to the Secretary March 7.

With less than 2 weeks remaining in our chartered life, it may be necessary to hold phone conferences on those issues that cannot be resolved at this meeting.

At the last meeting, reaching consensus was described as "what can you live with".

At this meeting, it may be "What can't you live with" and "How would you change it to gain acceptance"

TIMEFRAME for REPORT

Full report OUT BY (See Blair Potter for her edit times and availability) When is she available? When would she prefer to see the document? Can she make it one voice?

Conference Calls on Thursday February 28

Final Response Due back by COB March 5

To Secretary COB March 7

The White House Commission on Complementary and Alternative Medicine Policy was created March 8, 2000, by executive order. The 2-year commission will ultimately report to the president on legislative and administrative recommendations for ensuring that US public policy maximizes the benefits of complementary and alternative medicine. In this column, the chair of the commission will offer his thoughts about the goals and work of this key advisory body.

THE WHITE HOUSE COMMISSION AND THE FUTURE OF HEALTHCARE

James S. Gordon, MD

James S. Gordon chairs the White House Commission on Complementary and Alternative Medicine Policy and directs the Center for Mind-Body Medicine in Washington, DC. He is the author, most recently, of *Comprehensive Cancer Care: Integrating Alternative, Complementary, and Conventional Therapies (Perseus Press, 2000).*

Ninety years ago, at a time when medical education and the standards of physician practice were wildly variable, Abraham Flexner, a Carnegie Foundation consultant, issued a report titled *Medical Education in the United States and Canada.* Aided by the American Medical Association, Flexner graded North American medical schools according to the scientific standards of Johns Hopkins, which in turn was basing its rigorous curriculum on the German model. Flexner's report, with its emphasis on full-time faculty in the basic and clinical sciences and extensive laboratory and hospital facilities, set the standard for medical practice and licensing, as well as medical education, for the 20th century.

In July of this year, the newly appointed White House Commission on Complementary and Alternative Medicine Policy began to undertake a study that may conceivably exercise as profound an effect on 21st-century medicine as Flexner's report has had on 20th-century medicine.

The medicine that Flexner's report catalyzed, and the subsequent infusion of capital from John D. Rockefeller, helped to produce the extraordinary gains in scientific research, high-technology treatment of illness, and rigorous scientific education that have been the hallmark and pride of American medicine. But the medicine of Flexner's heirs, though enormously powerful and precise, has inevitably been incomplete.

In using a stringent set of criteria to judge medical education, Flexner, and those who followed his recommendations, eliminated some of the diversity that marked early 20th-century medicine. Schools of homeopathy—and those emphasizing herbal and natural healing—disappeared, as did a number of those serving women and minorities. The scientific medicine of the ensuing 90 years has made many advances, but in the process has ignored or dismissed many other healing traditions and many practices as having only historical, anthropological, or sociological interest.

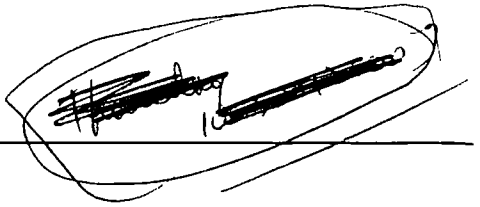
Over the last 30 years, increasing numbers of Americans have begun to experience the limitations of the medical care they receive and begun to look to these other traditions and practices to help them with their healthcare problems. In a very real sense, this search has been stimulated by the success of the Flexnerian enterprise. It is, in fact, those who have had all the benefits of modern scientific medicine who have led the search.

These people are not turning their back on conventional medicine, but they are painfully aware of its limitations and side effects and therefore are exploring approaches that would complement this medicine—or be alternatives to it. They include men, women, and children with life-threatening illnesses like cancer and HIV, and many more with chronic pain, chronic fatigue, fibromyalgia, neurological disorders, chronic depression, and a host of other conditions.

They are looking for therapies that are both more helpful and less toxic. As managed care becomes pervasive, many of these people are searching for something else as well. They want more time with the professionals who will provide care to them, a sustained healing partnership rather than a brief consultation, and an opportunity to participate in their own care as well as follow doctors' orders.

A survey published in the *Journal of the American Medical Association* in 1998 showed that 42% of all Americans were using therapies other than those their doctors prescribed, many along with and some without conventional care: chiropractic and massage for back pain; supplements and herbs for headaches, depression, diabetes, and weight loss; and a combination of dietary therapies, exercise, meditation, and group support as an option to cardiac surgery. In 1997 Americans made 649 million visits to alternative care practitioners, 243 million more than they made to their primary healthcare—MD—providers.

In fact, the actual number of Americans using these approaches is probably significantly higher than revealed in the survey. People who didn't speak English and didn't have phones were not included. Many of them are recent immigrants for whom what we call "alternative" or "complementary" is, in fact, primary care.



Coca-Cola To Purchase Odwalla

Fresh juice supplier Odwalla, Half Moon Bay, CA, has signed a definitive agreement with The Coca-Cola Company, Atlanta, GA, to become a separate business unit of The Minute Maid Company, Houston, TX, a division of Coca-Cola. Under terms of the transaction, Coca-Cola has agreed to acquire all outstanding shares of Odwalla common stock for $15.25 per share in an all-cash tender offer. After completion of the transaction, Odwalla will continue to be led by its current management.

ODS Launches Supplement Database, Funds Five Projects

The Office of Dietary Supplements at the National Institutes of Health, Bethesda, MD, recently released a database on dietary supplement research. The CARDS (Computer Access to Research on Dietary Supplements) database, which can be accessed at http://ods.od.nih.gov/databases/cards.html, is a database of federally funded research projects pertaining to dietary supplements. The development of CARDS was one of the specific mandates for ODS as part of DSHEA. CARDS currently contains projects funded by the Institutes and Centers of the NIH during fiscal 1999; the database will continue to be expanded to include projects from subsequent years and other federal agencies.

In other news, ODS will fund five new projects that examine the role of dietary supplements in disease prevention and health promotion. The projects will focus on current hot topics in the dietary supplement industry, including exploring the relationship between vitamin B supplementation and cognitive functions; the role of chromium supplements in the treatment of type 2 diabetes; the interaction between St. John's Wort and certain medications; the role of supplemental zinc in the treatment of HIV-related diseases and the development methods for the isolation and identification of plant chemicals.

NNFA, NSF Forge Dietary Supplement Certification Alliance

A partnership has been formed between NNFA, Newport Beach, CA, and NSF International, Ann Arbor, MI, for a comprehensive certification program for the dietary supplement industry. Through the partnership, NSF will use NNFA's Good Manufacturing Practices (GMP) materials as part of its Dietary Supplements Program and will recognize NNFA's GMP audits as meeting the requirements of the NSF Dietary Supplements Certification Program.

In other supplement certification news, the U.S. Pharmacopeia has officially launched its previously announced dietary supplement certification program.

Senate Allocates Funds To Implement DSHEA

In an amendment sponsored by senators Tom Harkin (D-IA) and Orrin Hatch (R-UT) to the Senate Agriculture Appropriations bill—HR-2330 —$1 million will be provided to FDA's Center for Food Safety and Applied Nutrition (CFSAN) to fund enforcement actions against dietary supplements that bear false or misleading labeling. In the same bill, an additional $3 million will be provided to upgrade and modernize the adverse event reporting system for dietary supplements. In a second amendment sponsored by the senators, the Labor-Health and Human Services (HHS) Senate bill—HR 3061—was amended to provide $500,000 to cover legal activities associated with enforcing product labeling provisions of DSHEA.

National Academy Considers Safety Of Supplements

A new committee at the National Academies of Science held its first meeting in October to discuss how FDA should address the safety of dietary supplements. The Committee on the Framework for Evaluating the Safety of Dietary Supplements includes a range of doctors and professors from across the U.S. The committee is charged with developing a proposed framework for categorizing and prioritizing dietary supplement ingredients based on safety issues and developing a system of scientific reviews with specifications for evaluating the safety of those ingredients.

high level task force to develop both immediate and longer-term solutions to these shortages. The conferees expect the Secretary to be prepared to discuss this issue and the status of the task force during the fiscal year 2003 budget hearings.

The conferees are aware that patients who suffer terminal illnesses face severe and excruciating pain. For such patients, palliative care is essential. The conferees are concerned that, although palliative care is well-established in many other countries, most of the American public and many health care professionals still know little about it. The conferees urge the Secretary to work with organizations like the American Medical Association and the American Board of Hospice and Palliative Medicine, to disseminate appropriate information to health care professionals and the public.

The conferees note that it has been seven years since enactment of the Dietary Supplement Health and Education Act and the Department has yet to promulgate good manufacturing practices regulations as called for under the Act. These regulations are crucial for consumer protection. The conferees strongly urge the Secretary to publish these regulations within 15 days of enactment of this Act.

The conference agreement includes $500,000 to augment the resources of the Office of General Counsel for enforcement of violations of DSHEA's labeling and content requirements as recommended by the Senate. The House had no similar provision.

The conferees understand the White House Commission on Complementary and Alternative Medicine will release its final report early in 2002. The conferees urge the Secretary to form a coordinating unit to review the Commission's report and implement ways to better coordinate the Department's many CAM-related activities.

A memorandum to Jim Gordon (and members of the White House Commission on Complementary and Alternative Medicine Policy):

Jim, I'm glad you found my earlier critique of the draft report helpful. You asked me to comment more specifically chapter by chapter. I have only a short time available this evening, but shall at least give it a try.

As noted earlier, the report has so many recommendations that one loses track of them. I think the Commission should prioritize the ones they most want to emphasize. Perhaps each of us should mark recommendations and action steps that seem the most critical to keep in the report. This memorandum will not attempt that. Instead it will share my overall reactions, chapter by chapter...

As you will see, I will be suggesting a different strategy for presenting the content of chapters four and six. My recommendations re: the kind of policy stance most likely to bring wide agreement with these chapters grows out of my own experience beginning in 1993. For four years I chaired a National Task Force of seventeen organizations that were attempting to write certification, training and performance guidelines for workplace health promotion. We faced similar issues to those confronting CAM policy advisers now, and my own first drafts were in many ways similar to the stance I see in WHC chapter drafts four and six. I learned the hard way that this approach can lose important support, and can splinter earlier effective coalitions. We regrouped, chose a slightly different strategy, and were eventually able to get national endorsement from a portion of the original coalition, after we had adopted an approach closer to the one I propose here. That experience colors my response to these chapters and the advice about that that I offer.

I hope these chapter-by-chapter summaries, taken from the notes I wrote in the margins as I read the draft, are useful. Best wishes to all, and congratulations on the progress made thus far. I think this can shape into a document that can have some real impact.

Now for the notes:

A missing ingredient that is much needed: An Executive Summary of no more than three to five pages.

Introduction and Chapter Two: The writing works fairly well, but the whole document will have more impact if it gets set in the context of larger public policy issues for which CAM developments could be relevant. (As discussed in my earlier note.) This could come either in the Introduction or in Chapter Two at the end. (Discussions in each later chapter then could point to their relevance for the policy issues identified early on in the Report.)

Chapter Three: This is a strong chapter. As I sketched out its argument and recommendation in my notes I wrote five comments in the margins:
"Recommendation 1, that federal agencies should receive increased funding for clinical, basic and health service CAM research, ignores what tax cuts have done to federal budgets. If this recommendation is taken seriously, it is likely to mean less funding for other activities. Given political pressures to protect current budget allocations, how can we make this more than a platitude? Should we specify how this might be done, in the present budgeting context, or simply leave it as a generalized wish?"

"Recommendation 3, action step 3.1: HOW should the Federal government stimulate private investment in research on CAM modalities and approaches designed to improve self-care and wellness behaviors? An excellent idea, but too vague."

Under Research Training and Infra-structure, just before Recommendation #8, I noted that "NCCAM seems to be planning to discontinue funding of CAM research centers and to be returning to simple funding of individual research or education grants. This will have implications for how CAM researchers collaborate and interact, and for the range of CAM-related activities they can undertake. Does the WHC want to address this, or not? Most of #8 assumes that the Centers will continue."

"Is it also important to strengthen the ability to study CAM when used outside conventional medical clinical settings for research?"

** **"Does 9.1 recommend the right agencies?** In my earlier testimony I had recommended giving NIH and AHRQ joint responsibility for conducting and updating systematic reviews of peer-reviewed research literature on safety, efficacy, and costs of CAM practices and products. Washington insiders took me aside and suggested that the National Library of Medicine might be better positioned to do this and might be freer from political pressures to shape reviews. They suggested that AHQR has received such heavy criticism that it is very cautious about what it does. Is this good advice?"

Chapter Four: Education and Training of CAM and Conventional Practitioners I had more trouble with this chapter, because I thought some of the recommended action steps did not recognize the range of useful CAM training programs that now exist. Some work well as they are, and might be hampered by trying to force them into the "alternative medical school" model that works well for chiropractery and naturopathy. Specifically,

1.6: Should CAM training programs be made more uniform? What will be gained? What will be lost?

1.7: Are we trying to convert all CAM practice to a variation on the medical model? For what kinds of training programs are common backgrounds in science, physiology, etc., as understood in western medicine needed? Might such training be superfluous, or hamper the kind of training being given in some modalities?

1.8: A good suggestion. Why not try it first with Chiropractic colleges and Colleges of Naturopathy?

1.9: An interesting idea. Voluntary or mandatory? And what content?

Chapter Five: CAM Information Development and Dissemination: An important topic. Some of the content of this chapter repeats what is elsewhere. We should decide what belongs where....

The first recommendation is too vague, and action step 1.2 seems too global. How would we accomplish that goal?

Chapter Six: Access to and Delivery of CAM: This chapter struck me as being the most problematic chapter in the report. It advocates a particular solution to problems of access and delivery, rather than laying out the problems that are under discussion, the range of solutions that are in contention, currently, and suggesting advantages and disadvantages of the various ways in which these issues currently are addressed. It totally ignores policy positions such as that adopted by the State of Minnesota, or the kinds of issues being looked at in California. If the chapter followed an alternate strategic approach, which I would recommend, it could acknowledge the variety of legitimate concerns that need to be addressed, the implications various solutions will have for the future, and pose a series of questions that need to be addressed when deciding these issues. I think it is important for this to be done. If the chapter does not take this kind of "balanced approach" it will generate contention and distrust, and the Commission might get charged with attempting to railroad solutions that benefit one CAM interest group at the expense of others. Some groups within CAM will see the present chapter as offering a version of the "AMA strategy" that was used in the early 20th century, when many of the traditions now seeking a legitimate role in health care were forced to the sidelines through political means. I think it is important to avoid that kind of labeling of the Commission's work.

More specific comments on chapter six:
Recommendation #1 will take the Commission into a highly political and politicized arena. I think it is unrealistic to assume that all states will follow a uniform set of recommendations, or that those who do accept such recommendations will apply them uniformly.

Instead, why not emphasize that regulatory reform is needed, and perhaps discuss how different types of regulatory reform will affect present CAM practice and its relation to conventional medicine?

I have not read the Federation of State Medical Boards' model guidelines to regular "unconventional medical practice", but I wondered whether State Medical Boards' concerns provide an appropriate model for us... E.g., One of the unresolved struggles within CAM concerns the extent to which MDs will dominate decision-making and practice for CAM uses. Without further explanation, this proposal sounds like it might be "asking foxes to guard the henhouse". Perhaps that's unfair. If p 8 spelled out what their model guidelines look like, readers could judge for themselves. The first paragraph of p 9 might be all right.

Recommendation #2 and its action steps, if adopted, could set in motion a set of dynamics that would change the historic character of much of CAM. Thus this recommendation and the way it is discussed in this draft could set off a hue and cry within the CAM constituency that could dissipate support for the Commission and its work. The chapter and its recommendations, as currently drafted, runs the risk of generating hostile reactions that could dominate discussion of the entire report.

(I am not suggesting that the Commission needs to avoid all controversy. Rather, the FIRST White House Commission of CAM Policy needs to set a tone for future discussion of contentious issues.)

I think the subject matter of this chapter would be better addressed by spelling out the issues that need to be considered when adopting policy in this area: e.g., protection of the public, maintaining free competition in the provision of CAM services, protection and preservation of CAM styles and traditions of working, freedom to choose health workers in whom one has confidence, etc. (I haven't thought out these parameters very well, but they at least get one started.) Then one can discuss the different solutions that are being advocated, and their advantages and disadvantages for each of the concerns you have identified. One might propose careful observation of the experiments currently underway re: regulation in different states, and propose a series of questions to ask about their effects over time. The answers to these questions, then could guide policy groups in the future who try to address these issues....

Chapter Seven: Coverage and Reimbursement is a strong chapter, overall. I suggest that the Commission should decide whether it is advocating "cost-benefit" studies or "cost effectiveness" studies. These have rather different implications for what one analyzes and how one draws conclusions. (I suspect you want to recommend "cost-benefit" analysis, which normally utilizes a much less complex set of variables and shorter time spans.)

On p 5, lines 14-23 strike me as making a somewhat naïve argument, that might be dismissed by health policy experts. "interventions known to be safe and beneficial should be reviewed and given consideration for coverage under health benefit programs (whether conventional medicine or CAM). I agree with the principle, but this recommendation ignores how benefits payments actually work. If something is an accepted procedure for reimbursement, it gets reimbursed **regardless of what else also is being done.** Thus adding CAM procedures to the approved list does nothing to discourage continuation of other, more expensive and possibly less effective treatments. Every time you add something to the approved benefits list you increase the cost for care-- This means that in order for such a recommendation to be taken seriously, and implemented, we will need to suggest a way to do this that leads to use of the cheapest and most effective strategies for dealing with a health problem, rather than a proliferation of health care costs.

"Equitable and impartial consideration of safe, effective CAM interventions—Coverage policies and processes need to indicate how to do this without escalating total health care spending.

What do we mean by "medically necessary" on pp 17-18?

Under discussion of the Tax Code, what about suggesting "performance-based" tax credits for CAM and prevention programs that lower health risks, during the time period before lowered disease care costs will compensate for the additional costs incurred in using these strategies? (action step 2.6 also)

Recommendation #2 might need an additional clause, such as this: "and develop reimbursement strategies that will encourage use of those services that are most effective for the least cost"

Chapter Eight: CAM in Wellness and Health Promotion has some excellent proposals, but the "voice" of the chapter needs work in order for it read persuasively.

Recommendation #1 probably needs rewording. We seem to advocate use of CAM and then ask for research to see if it works.... The last paragraph on p 8 seems to hand over responsibility for CAM promotion to groups unlikely to make this a high priority (e.g. Institute of Medicine and Public Health Association).

Recommendation # 2 and action steps 2.1 and 2.2 strike me as excellent.

The sidebar for workplace health promotion is excellent

Recommendation #3, action step 3.2 needs rewording. And here might be a place to advocate performance-based tax incentives....

P 13 "Federal programs should serve as a model..." How? And how relate this to cost-benefit concerns? Recommendation 4, action step 4-1 strikes me as too vague. It lists several agencies that should incorporate safe and effective CAM practices into their services, but does not suggest what or how.

4.3 struck me as particularly promising.

I also really liked 4.5, but wanted a bit more specificity about how this might be done.

Chapter Nine: Coordinating Federal CAM Efforts has some intriguing suggestions.

I would recommend changing some of the language used to describe the Advisory Council: "would bring together the various stake holders in CAM to develop an agenda that reflects public opinion" This language can be read as meaning that people with vested interests and money in the CAM community will shape public opinion. Some word other than "stake holders" might serve better.

I think the recommendation sets too limited tasks for this office: The office should do more than "coordinate and facilitate the **integration** of safe and effective complementary and alternative health care practices **into the nation's health care system**". It should also help preserve the independence of alternative medicine, etc., etc.

This chapter will be appealing IF chapters four and six have more balanced discussion of the issues they address, and IF chapter seven can address inclusion of reimbursement in a context that does not threaten major escalation of health care costs. If those problems are not addressed, various public interests are likely to resist creating a federal agency that could play a role they would consider as detrimental to the public's interest, or that might become a vehicle for interest-group domination of decision making.

This chapter provides a potentially attractive solution to how to move forward. This should not be the final ending note, however. **There needs to be some kind of summary statement that provides a powerful emotional appeal for proceeding with the agenda laid out in this report.**

Steve Casaday
4-4-91

CAM offers numerous potential benefits to the Public.

The Public needs access to S+E CAM practices and products from appropriately trained and qualified practitioners ~~that~~ ~~Provide~~ Consumers need reliable and useful information about CAM practices and products to protect them for false and misleading claims about ineffective

The considerable amount of Research is still needed to determine the S+E of CAM practices through objective rigorous studies + reviews

CAM can provide benefits to the public. More research is needed to develop reliable and useful information that can be used to substantiate differentiate from unproven controlled studies the claims of safe and effective products and practices provided by qualified practitioners from false and misleading claims about ineffective or unsafe products and interventions.

Groft, Stephen (NCCAM)

From: Linnea Larson [linnealarson@mac.com]
Sent: Thursday, January 31, 2002 4:49 PM
To: Groft, Stephen (NCCAM)
Subject: Re: ACCME CAM & CME

on 1/31/02 3:18 PM, Groft, Stephen (NCCAM) at grofts@od31em1.od.nih.gov wrote:

> Linnea,
>
> Thank you for the information. Can you fax a copy of the proposal after you receive it? Did you get a big snow storm in Chicago today or am I dreaming? If the latter, I better get out of here for a bit.
>
> Steve
>
> > -----Original Message-----
> > **From:** Linnea Larson [mailto:linnealarson@mac.com]
> > **Sent:** Thursday, January 31, 2002 12:12 PM
> > **To:** Groft, Stephen (NCCAM)
> > **Subject:** FW: ACCME CAM & CME

Dear Steve, I just received this email. Thought you would find this of interest.
Take care,
Linnea

From: WDRutenber@aol.com
Date: Thu, 31 Jan 2002 00:10:02 EST
To: linnealarson@mac.com
Subject: ACCME CAM & CME

Linnea, I hope this email finds you well. I trust you are not too overwhelmed by the WHCCAMP workload especially in view of the recently added meeting of the commission. I just received from our executive director a copy of a "Call for comments and input" from the Accreditation Council for Continuing Medical Education (ACCME) regarding a change in their policy for validating the content of CME education. The AAMA is concerned that this will negatively impact the educational goals of the Commission, which the AAMA endorses. I would like to fax the information to you (if you would be so kind to send me your fax number) with the hope that you and the commissioners will be similarly concerned that although cloaked in terminology, the hidden agenda is intended to restrict and limit courses and CME offerings in the complimentary and alternative medicine fields. If the potential detrimental impact of this ! policy change is shared by the commission, perhaps the commission would respond to the ACCME, voicing the commission's concerns and offering constructive suggestions to improve CAM CME.

With best personal regards,
Bill

William D. Rutenberg, M.D., D.A.B.M.A.
Member, Board of Directors
Chair, Medical Acupuncture Advisory Committee
American Academy of Medical Acupuncture
Tel: 847-634-4728

Groft, Stephen (NCCAM)

From: Linnea Larson [linnealarson@mac.com]
Sent: Tuesday, February 19, 2002 3:47 PM
To: Groft, Stephen (NCCAM)
Subject: FW: Proposal for reviewing report document

Importance: High

Steve, This memo I sent out last night was just returned to me. I did not know that you had not received it until a minute ago. These criteria I have used in reviewing the document resulted in my not being able to assent to the document as it stands. Jim Gordon called me yesterday to ask my suggestions. This is what I told him.
Take care,
Linnea

From: Linnea Larson <linnealarson@mac.com>
Date: Mon, 18 Feb 2002 19:39:50 -0600
To: "James S. Gordon" <jsgordon@mindspring.com>, <grofts@od.nih.gove>, Joseph Pizzorno <drpizzorno@salugenecists.com>, Buford Rolin <tierney334@yahoo.com>, "Conchita M. Paz" <cmapaz@totacc.com>, David Bresler <bresler@aol.com>, Dean Ornish <DeanOrnish@aol.com>, Donald Warren <drwarren@artelco.com>, Effie Poy Yew Chow <eastwestqi@aol.com>, "George M. Bernier,Jr." <gbernier@utmb.edu>, George DeVries <georged@ashn.com>, "Joseph J. Fins" <jjfins@med.cornell.edu>, Julia Scott <jrsct6@cs.com>, Thomas Chappell <Tom@toms-of-maine.com>, Tieraona Low Dog <lowdogmd@aol.com>, Veronica Gutierrez <Veronicapgdc@aol.com>, Wayne Jonas <WBJonas@aol.com>, <mingtian@aol.com>
Cc: Joseph Kaczmarczyk <kaczmarj@od.nih.gov>, Michele Chang <changm@od.nih.gov>, Corinne Axelrod <axelrodc@mail.nih.gov>, Kenneth Fisher <Fisherk@mail.nih.gov>, Maureen Miller <millemau@mail.nih.gov>, <polleng@od.nih.gov>, Doris Kingsbury <Kingsbud@mail.nih.gov>, Jim Swyers <jpswyers@starpower.net>
Subject: Proposal for reviewing report document

Dear Good People,

I would like to propose that in the next two days we examine the report document with reference to the following four (4) criteria:

Rationale

1. Recommendation and action steps must have a convincing rationale in the text.

Rhetoric/Specificity

2. Recommendation and action steps that can be specific about a CAM modality/technique/profession/system must be so and not refer to CAM in general. Not doing so results in muddled thinking and florid CAM rhetoric.

Public Policy

3. Recommendations should be limited to matters of Federal public policy. (see memo of Feb 4)

Executive Order

4. Recommendation and action steps should address the four investigation topics listed in the Executive Order.

Example of meeting the four criteria will be given at the meeting.

Respectfully,

Linnea

To Jean
From Ever

The Future of Medicine

In my 55 years as a physician, I've seen my share of what modern medicine can do. During the 40 years when I was a pediatric surgeon, I saw 95% mortality rates for congenital defects transformed into 95% survival rates because of what surgery can accomplish. As U.S. Surgeon General, I saw effective prevention and treatment techniques beat back the mortality from tobacco use and AIDS. And now, as an 85-year-old, my life has been prolonged and kept active by wonder drugs unknown to my parents. So it's been somewhat surprising in this era of triumph for modern medicine to see the rapid growth of alternative/complementary medicine, which is used by as many as one in three Americans. Although most of those still refrain from informing their regular physicians about that use, there is a growing tendency among physicians to acknowledge and even embrace certain forms of alternative/complementary medicine.

Changes in the use of the terms "alternative" and "complementary" suggest the shape of this shift. At first, it was called simply "alternative medicine," reflecting a dissatisfaction with regular medicine as well as a cultural rebellion against the biomedical community. In more recent years, several studies indicate that there has been a shift from "alternative" therapies to "complementary" therapies, adopted not in opposition to regular medicine but in alliance with it. And increasingly those who use one of the many forms of complementary medicine are not treating a specific medical problem. Rather, they are practicing prevention in ways they find more congruent with their philosophical values or lifestyle.

The natural products industry should work with medical research and the FDA.

Now I think we may be seeing another refinement, one that is taking us from "complementary" to "safe and effective." For some people, the appeal of alternative medicine lies in its alternative stance, and as some of these therapies enter the mainstream, some of these individuals may seek other alternative practices. But more and more Americans are demanding greater certainty from alternative or complementary products as an increasing number of press reports document health problems resulting from certain natural products and complementary practices. Thus, the baby-boom health consciousness that led to the resurgence of alternative/complementary medicine now turns toward solutions that rest more heavily on science. We went through a somewhat similar passage a century ago, when dissatisfaction with regular medicine and a growing consumer market in health products led to the widespread use of a variety of nostrums and patent medicines; some no doubt helpful, some merely enjoyable, and some downright dangerous. At that time, journalists and the public pressed for scientific research to support proper branding and safety, culminating in the Pure Food and Drug Act of 1906. Much later, evidence of effectiveness was added to the list. Some among the sellers and buyers of health products objected at first to the intrusion of research-based evaluation into the health market, but soon both came to profit from increased consumer confidence in those health products.

For too long, the natural health products industry has kept its distance from medical research and from clinical medical practice, focusing instead on the short-term marketing advantages derived from keeping herbal and nutritional remedies exempt from any Food and Drug Administration (FDA) review of efficacy. A wiser approach would be for the natural products industry to work with medical research, including the FDA, so that consumers and medical practitioners could be warned about potential harm and assured that the claimed health benefits were really there. Although the growth in the use of alternative/complementary medicine is likely to continue, recent surveys and market data confirm a growing American concern about safety. In this new climate of national wariness and concern for personal safety, those interested in selling and buying natural products associated with complementary medicine will be better off in the long run if reliable research is able to certify their safety and efficacy. As America's baby boomers become senior citizens, the health care system needs the relief provided by effective prevention of disease and disability. There is a potential role for some complementary therapies and natural health products in preparing us to meet the challenges of the 21st century. But it can only be played if that industry and its proponents are prepared to meet real scientific and regulatory tests of safety and effectiveness.

C. Everett Koop

C. Everett Koop is the Elizabeth DeCamp McInerny Professor of Surgery at Dartmouth Medical School and a former Surgeon General of the United States.

202-363-7247

10-4

662 Total

296 (10 meetings) 376 (4 Town Hall)

① 7/13 - 7/14 (12)

Ⓐ Town Hall SA 52 ° 9/8 40

Ⓒ 10/5 - 10/6 Renewal 40 x 10

Ⓑ Town Hall Health 116 ° 10/30 & 10/31

③ 12/4 - 12/5 Account + Delivery 61 x 10

Ⓒ Town Hall K4C 135 ° 11/23/01

④ 2/22 - 2/23 / Ed Training 39 x 10

Ⓓ Town Hall Mennenpolis 73 ° 3/16

⑤ 3/26 - 3/27 Information 50 x 10

⑥ 5/14 - 5/16 Reimbursement 61 70

Leon ⑦ 7/3/01 Public 7

⑧ 10/4 10/6 6

⑨ 12/6 - 12/7 10

⑩ 2/21 - 2/22

FDA Commissioner

Study Recommendation

Short term
Long term
} Goals

Recommendations

— Voice of Community
Ongoing Adv Committee

Groft, Stephen (NCCAM)

From: Veronicapgdc@aol.com

Sent: Monday, January 14, 2002 11:42 AM

To: Groft, Stephen (NCCAM); drpizzorno@salugenecists.org; tierney334@yahoo.com; cmapaz@totacc.com; Bresler@aol.com; DeanOrnish@aol.com; drwarren@artelco.com; EastWestQi@aol.com; gbernier@utmb.edu; georged@ashn.com; jsgordon@mindspring.com; drpizzorno@qwest.net; jjfins@mail.med.cornell.edu; Jrsct6@cs.com; linnealarson@mac.com; Tom@toms-of-maine.com; Lowdogmd@aol.com; wjonas@usuhs.mil; DrFair@haelth.com; MingTian@aol.com

Cc: Axelrod, Corinne (NCCAM); Chang, Michele (NCCAM); Fisher, Ken (NCCAM); jpswyers@starpower.net; Kaczmarczyk, Joseph (NCCAM); Kingsbury, Doris (NCCAM); Miller, Maureen (NCCAM); Pollen, Geraldine (NCCAM)

Subject: Re: Draft Final Report Sections - Deadline January 25 Noon

Dear All,

Sat down last night to read all the sections from beginning to end and would like to make the following comments.

1. Found "pedogogic" used five times in Education and Training. Thought that was quite a few times for a word I use maybe once every five years. Slowed my reading!!

2. Education and training. My page 7. Paragraph beginning, "Table (fill in the number...). Last sentence states "practicing physicians" REMOVING a CAM modality in the patient's care plan." I don't remember any such discussion. I don't like the "gatekeeper" mentality. Shouldn't a consultation with the CAM provider occur before REMOVING of a modality occur?

3. Education and training. My page 11. Paragraph beginning, "This core curriculum..." The suggested deletions in ( ) and changes in caps.

This core curricullum should incllude clinical competencies such as (medical) record keeping, knowledge of medico-legal aspects of care.....team." The curriculum also should include recognition of the limits of (one's) EACH PROVIDERS clinical expertise....complications, (of CAM interventions and) indications, and mechanisms for appropriate referral to (conventional) OTHER health care providers.

4. Access and Delivery. My page 9. **Arguments for regulating CAM**
Most licensed practitioners must follow a legal and/OR ethical code to refer the patient to another licensed (medical) health care....."

5. Coverage and Reimbursement. My page 16. Paragraph beginning: "The public and private methods..... Line 5. Wordsmithing missed the phrase "medical" necessity. CLINICAL would work more appropriately for all groups addressed.

6. Coverage and Reimbursement. My page 17. Paragraph beginning: "To make coverage of CAM.... (medical) add CLINICAL. Same comment as #5.

7. Information & Dissemination. My page 1. Paragraph 3. Sentence 2. "This includes information to help choose the most appropriate type of practitioner, decide on what type of (treatment) APPROACH or CARE can benefit....."

8.Information & Dissemination. My page 3. **Issue 1** Readers of the document may appreciate having the toll free phone number of the NCCAM Clearinghouse referenced in paragraph 2.

9. Information & Dissemination. My page 4. Paragraph before **Issue 2** .
Recommendation 1). Why was this directed to a task force instead of the new Office?

10. Information & Dissemination. My page 10. Paragraph before **Recommendation** 10). I believe that

"Current FTC effort should be significantly expanded to decrease the amount of false or deceptive advertising, solicitf public comments on CAM advertising, and expand the utiflization of CAM experts in the process of examining these advertisements" needs to be stronger than a text comment and needs to be a specific recommendation. For a legal perspective on the chiropractic experience with the FTC, contact Jim Turner @ 202-462-8800.

11. Research. My page 1. Paragraph 3. I cannot make this paragraph flow. And, it was Bill Fair who (in November according to my notes) made the comment that "medical research is not 100%".

lines 2-3. (therapies) add APPROACHES

12. Research. My page 9. **Action Items** 1.1. Shouldn't this activity be encouraged to be directed to the new Office?

13. Research. My page 12. Above **Recommendation 7** (therapeutic) CLINICAL.

I have a little more reading to do, but wanted to send this out this a.m. We'll be out of town from the 16th thru the 20th.

I'm looking forward to receiving the Definition and History component.

Thank you!!

Veronica

Groft, Stephen (NCCAM)

From: Veronicapgdc@aol.com

Sent: Monday, January 21, 2002 4:49 PM

To: Groft, Stephen (NCCAM); tierney334@yahoo.com; cmapaz@totacc.com; Bresler@aol.com; DeanOrnish@aol.com; drwarren@artelco.com; EastWestQi@aol.com; gbernier@utmb.edu; georged@ashn.com; jsgordon@mindspring.com; drpizzorno@salugenecists.com; jjfins@mail.med.cornell.edu; Jrsct6@cs.com; linnealarson@mac.com; Tom@toms-of-maine.com; Lowdogmd@aol.com; wjonas@usuhs.mil; DrFair@haelth.com; MingTian@aol.com

Cc: Axelrod, Corinne (NCCAM); Chang, Michele (NCCAM); Fisher, Ken (NCCAM); jpswyers@starpower.net; Kaczmarczyk, Joseph (NCCAM); Kingsbury, Doris (NCCAM); Miller, Maureen (NCCAM); Pollen, Geraldine (NCCAM)

Subject: Re: FW: Background Information - Introduction and Consolidated Recomm endatio...

Dear All,

Just finished reading the new material. Thank you.

I must repeat again that I have some problem with the wording of Guiding Principle #5. My dictionary defines "therapy" as "the treatment of disease or of any physical or mental disorder by medical or physical means, usually excluding surgery."

I believe it was our intent to allow the consumer to "choose freely among safe and effective care/approaches to promote health and self-care.

"Therapy" continues to promote the concept of diagnosis and treatment alone and is not inclusive of all of the complementary and alternative approaches we have discussed.

#7. I would like to suggest again that "CAM" in this principle be changed to Complementary and Alternative Health Care.

If anyone feels these changes would change the integrity of the Principles, please let me know.

Veronica

Groft, Stephen (NCCAM)

From: Chang, Michele (NCCAM)
Sent: Tuesday, January 15, 2002 4:30 PM
To: Axelrod, Corinne (NCCAM); Fisher, Ken (NCCAM); Gerry Pollen (E-mail); Jim Swyers (E-mail); Joe Kaczmarczyk (E-mail); Kingsbury, Doris (NCCAM); Miller, Maureen (NCCAM); Steve Groft (E-mail)
Cc: Donald Warren (E-mail)
Subject: Dr. Warren's comments

These comments were called in by Dr. Warren. He may add others upon his return from his conference in...Maui?

Overall, he liked the report and felt it flowed well. He rated the tone of the report as "fair" (as in balanced).

INFO Section: pgs 16-17...text leaves reader unclear if criticisms of AER are because of the system itself or because current AER systems are drug-specific, rather than supplement inclusive.

RESEARCH:
Pg 13: line 27....Examples of interdisciplinary activities [THAT] have contributed
14:19....why people are turning to CAM points to the need [TO] learn more about why people

COVERAGE
4:113/114...lack of knowledge about CAM (and negativity), [Donald is unclear WHO's negativity is being referred to in this sentence]
8:235...The federal tax code is another area that can be use[d]
8:243-244...benefit packages [that would] incorporate safe and beneficial CAM interventions that [current do not?] fully qualify as deductible expenses under current law and regulations.
18:537...allaying symptoms or side-effects of conventiona[L] treatments

ACCESS:
1:22..doctor visits by 37[%],
4:24...series of report[S}
5:4...in a[N] effort
9..bolded text should not be bolded (unnecessary emphasis)
14:26...health professionals [TO] evaluate
19:8...related to the licensing and certification of CAM practitioners [CHANGE TO REGULATION OF CAM...]

EDUCATION AND TRAINING
17:34.....missing "ACTION ITEM" header.

Michele M. Chang, MPH, CMT
Executive Secretary
White House Commission on
Complementary and Alternative Medicine Policy
tel: 301-435-6232
fax: 301-480-1691
website: whccamp.hhs.gov

Revised Outline for WHCCAMP Report (11-28)

Letters of Transmittal
- From the Secretary, DHHS to the President
- From the Secretary, DHHS to the Congress
  - From the Secretary to the President of the Senate
  - From the Secretary to the Speaker of the House
- From the Chair, WHCCAMP to the Secretary, Department of Health and Human Services

Prologue – Chairman's Summary
Commission Members
Commission Staff
Working Groups (Planning)
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Part VII: Coverage and Reimbursement of CAM

Part VIII: CAM Information Development and Dissemination

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Part X: Vision for the Future

Part XI: List of Recommendations and Suggested Implementation Strategies

Part XII: Glossary and Acronyms:

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SG120301

For Consumers and Practitioners

NCCAM NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

Related Federal Links

CAM Information at Other U.S. Federal Agencies

- **Agency for Healthcare Research and Quality (AHRQ):**
  - Ayurvedic Interventions for Diabetes Mellitus
  - Garlic: Effects on Cardiovascular Risks and Disease
  - Mind-Body Interventions for Gastrointestinal Conditions
  - Milk Thistle: Effects on Liver Disease and Cirrhosis and Clinical Adverse Effects
- **Department of Health and Human Services (DHHS):**
  - White House Commission on Complementary and Alternative Medicine Policy
  - Integrative Medicine and Alternative Health Practices Initiative
- **Federal Trade Commission (FTC):**
  - Consumer Education on Diet, Health and Fitness
  - FTC Consumer Feature: Promotions for Kids' Dietary Supplements Leave Sour Taste
- **Food and Drug Administration (FDA):**
  - Center for Food Safety and Applied Nutrition: Dietary Supplements
  - Center for Food Safety and Applied Nutrition: Products that Consumers Inquire About
- **Library of Congress (LOC):**
  - LOC Online Catalog
  - Thomas Online Legislative Information

CAM Information at the National Institutes of Health (NIH)

- **NIH Toll-Free Information Lines**
- **Complete List of NIH Institutes, Centers and Offices**
- **National Cancer Institute (NCI):**
  - The Office of Cancer Complementary and Alternative Medicine (OCCAM)
- **National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK):**
  - NIDDK Information: Alternative Therapies for Diabetes
- **National Institute of Environmental Health Sciences (NIEHS):**
  - NIEHS Consumer Information on Alternative Medicine
  - NIEHS Research Initiatives: Herbal Medicines
- **National Institute of Mental Health (NIMH):**
  - NIMH Questions & Answers about St. John's Wort
- **National Library of Medicine (NLM):**
  - CAM on PubMed
  - MEDLINE Plus Alternative Medicine Information Sheet

- NLM FAQs: Dietary Supplements, Complementary or Alternative Medicines

- **NIH Consensus Development Forum:**
  - Acupuncture: NIH Consensus Statement, Vol. 15, No. 5, 1997
  - The Integration of Behavioral & Relaxation Approaches in the Treatment of Chronic Pain & Insomnia: NIH Technology Assessment Conference Statement, Oct. 16-18, 1995

- **The Office of Dietary Supplements:**
  - The International Bibliographic Information on Dietary Supplements (IBIDS)

NCCAM Home / Consumers and Practitioners

Menu...

Please send questions and comments tonccam@nccam.nih.gov.

Last Updated: 10/26/01

Report of the White House Commission on Complementary and Alternative Medicine Policy

Letters of transmittal
- The President
- Congress
  - President of the Senate
  - Speaker of the House
- Secretary Department of Health and Human Services

Prologue – Chairman's Summary – 1 page vision
Acknowledgements
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Working Groups (Planning)

Executive Summary (10 pages)
- Conclusions
- Recommendations (a) Administrative Actions
  (b) Legislative Proposals

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  (4) Evaluation of Interventions by non-traditional Research methods

(F) Support for Research
  (1) Basic Research
  (2) Clinical Research
  (3) Health Services Research
  (4) Epidemiological/Follow-up Long Term Studies
  (5) Existing Sources of Funding
  (6) Research Opportunities In Waiting
  (7) The Research Community; Perceptions and Realities of Support for CAM Research
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(C) CAM Delivery Systems
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    (b) Community Hospitals
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    Ohio
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(B) Overcoming the Stigma of CAM Practices **(?)**
(C) Increasing Public Awareness of Safe and Effective Interventions
(D) Ensuring Access and Delivery of CAM Intervention and Products
(E) Providing Access to Culturally Specific Interventions in a Nactive population
(F) Eliminating Financial Barriers to Interventions
(G) Reducing Regulatory and Legal Constraints
(H) Aiming Towards Parity in Research , Training, and Education of CAM Practitioners and Researchers
(I) Providing Adequate Reimbursement for Services Provided

Groft, Stephen (NCCAM)

To: Commissioners E-mail; drpizzorno@salugenecists.org
Cc: WHCCAMP Staff
Subject: Draft Final Report Sections - Deadline January 25 Noon

Attached are the Draft Sections of the Final Report. As you know, the individual workgroups and the staff leads have devoted considerable time to the development of the individual issues as presented in these drafts. Our reading and editing now becomes the focus of the Commission as we draw near to the completion of our task. Please note the absence of the Introduction and the History of CAM with the guiding principles. These will be sent to you next week as well as a consolidated list of Recommendations and Action Items. We have kept Jim Swyers very busy editing the other sections. I felt Jim needed a few extra days to catch his breath and then address the Introduction and History Sections. The Workgroup has been busy reviewing and revising the existing text.

At this point in time, we would like to ask you to read the sections of the report as presented with the knowledge that you will get a chance to review a more refined, and further edited version around FEBRUARY 14. We need your comments on the Tone and Flow of the document. Have we written what you think we should have written? Are there omissions that should be included? Should sections be deleted or changed to provide a different emphasis? Is there appropriate balance to the document? ... Not too Negative and Not too Positive.

The Commission has moved from hearing testimony, through the development of recommendations, action items, and text by the workgroups, to the beginning of the Final Report. Some inconsistencies still remain in the format. Although additional editing will help to remove these differences, we still need you to identify and bring them to our attention. We have discussed the need to edit the document to provide a better flow to the content of the document, to complete the transfer of an issue to another section of the report, and to develop a more readable document. This will require some reorganization and editing as we hear from you and your suggestions.

If you have comments or concerns about the content of this draft, please share them with the rest of the Commission. You may do this by clicking on the Reply to All block on your screen. Some of the ideas may serve as a thread for others to build on with their comments. These comments should help us to identify issues that need more discussion and attention. **Please note the DEADLINE for your comments is Friday January 25 at NOON.**

Thank you for your assistance and guidance.

Jim Gordon

Steve Groft

CAM Central Jan 02 JMK ... | v5 11 | Wellness11Jan02CA.rtf | InfoDevelopDissem 11Jan02CA.rtf... | AccessandDeliveryJAN1101#5.Irt... | ResearchCoord11Jan02GP.rtf | CoverageandReimbursMMjan1102.r... | Ed Training 11 Jan 02 Draft Ve...

Groft, Stephen (NCCAM)

From: Kenneth Fisher [kfisher@erols.com]
Sent: Tuesday, December 18, 2001 7:37 AM
To: steve groft
Subject: Gordon and GMPs

If you talk to Jimbo today, you might modify what I said about GMPs just so he doesn't get it wrong. DSHEA does say something about GMPs in section 8. But what it says is that the Secretary can develop GMPs specifically for dietary supplements (AND THAT'S WHAT THE INDUSTRY FOLKS DID, BY DEVELOPING THE DRAFT GMPs RIGHT AFTER THEY GOT DSHEA PASSED).

DSHEA also says that the food GMPs are a model for the DS GMPs, which again is what the industry folks used in preparing the draft in 1995-96.

The joker in the deck is that any GMP standards can be promulgated if there is no curent and generally available analytical methodology (for identification). Score one for the industry as in 1995-96, and even now, accepable analytical methodology is incomplete. (A real Catch 22 situation here). It may be that the reporter was probing about this point. However, USP and others are now hot on the trail of developing standards with current analytical methodology.

Its a minor point, but needs clarification. I misspoke when I implied DSHEA was silent on GMPs.

kdf

Apologetics Index

Bhagwan Shree Rajne
An Apologetics Index research reso

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Bhagwan Shree Rajneesh (1931 - 1990)

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Name Change

Articles News Database See Also

Rajneesh founded the Rajneesh Foundation International, and is one of the most controversial of modern gurus. In 1981 he was deported from Oregon under a bevy of serious criminal charges associated with his ashram, or spiritual community. His recent death did little to stem his influence in Europe or America.

John Ankerberg and John Weldon, Encyclopedia of New Age Beliefs Harvest House Publishers, Oregon, 1996.

[A]lso called OSHO AND ACHARYA RAJNEESH, original name CHANDRA MOHAN JAIN, Indian spiritual leader who preached an eclectic doctrine of Eastern mysticism, individual devotion, and sexual freedom while amassing vast personal wealth.
(...)

In 1981 Rajneesh's cult purchased a dilapidated ranch in Oregon, U.S., which became the site of Rajneeshpuram, a community of several thousand orange-robed disciples. Rajneesh was widely criticized by outsiders for his private security force and his ostentatious display of wealth. By 1985 many of his most trusted aides had abandoned the movement, which was under investigation for multiple felonies including arson, attempted murder, drug smuggling, and vote fraud in the nearby town of Antelope. In 1985 Rajneesh pleaded guilty to immigration fraud and was deported from the United States. He was refused entry by 21 countries before returning to Pune, where his ashram soon grew to 15,000 members. In later years he took the Buddhist title Osho and altered his teaching on unrestricted sexual activity because of his growing concern over AIDS.
[...more...]

Rajneesh, Bhagwan Shree Encyclopedia Britannica

(...) the only known successful use of biological weapons in the United States was by the Bhagwan Shree Rajneesh cult in 1984. The group contaminated salad bars in 10 restaurants in The Dalles, Ore., with Salmonella Typhimurium, causing several hundred people to become ill.

Biological and Chemical Warfare Q and A, ABC News, Sep. 24, 2001

Hinduism is not by nature a proselytizing religion, however, in part

because of its inextricable roots in the social system and the land of India. In recent years, many new gurus, such as Bhagwan Shree Rajneesh and Satya Sai Baba, have been successful in making converts in Europe and the United States. The very success of these gurus, however, has produced material profits that many people regard as incompatible with the ascetic attitude appropriate to a Hindu spiritual leader; in some cases, the profits have led to notoriety and even legal prosecution.

Hinduism Outside India↗ Encyclopedia Britannica

Name Change

In 1988 thirty years after taking the title, "Bhagwan," (which means "the embodiment of God") Rajneesh admitted the title and his claim to be God were a "joke." "I hate the word... I don't want to be called Bhagwan (God) again. Enough is enough. The joke is over," stated Rajneesh saying he was really the reincarnation of Buddha and claiming for himself the new title of "Rajneesh Gautaman the Buddha," (Star Telegram, Dec. 29, 1988; Sec.1, p. 3). Later he took the title, "Osho Rajneesh," a Buddhist term meaning "on whom the heavens shower flowers." (Ibid, 1/20/90).

Guru Rajneesh Dead at 58↗, Watchman Expositor, Vol. 7, No. 2, 1990

- Articles -

» See also the articles in our news articles database

- Guru Rajneesh Dead at 58↗, Watchman Expositor, Vol. 7, No. 2, 1990
- Old Bhagwan, new bottles↗ "A 'new' spiritual guru turns out to have a past that includes lavish spending, orgies and bacterial terrorism.", Salon.com, Oct. 20, 1999

  Ever wonder what ever happened to the guy whose religious followers were linked to the only episode of domestic mass bioterrorism in America? Well, in the case of the late, notorious Bhagwan Shree Rajneesh, old renegade sex gurus never die. He just "left his body" somewhere in India in 1990 and later emerged as a thriving, modern-day publishing machine known as Osho.

  Rajneesh's flock caught much of his meditative bon mots on tape, and now incessantly recycle these ponderings as spiritual wisdom under the author name of Osho.

- Rajneesh, Bhagwan Shree↗ Entry in Encyclopedia Britannica
- Rajneeshpuram: Another Tragedy in the Making?↗ Statement by the Christiar Research Institute
- The Story of a Truly Contaminated Election↗ Columbia Journalism Review, Jan/Feb 2000

  The only proven incident of bioterrorism the United States has ever experienced, we learned, was a bizarre plot by the Rajneeshees, a religious cult, to steal a county election in Oregon in 1984. The Rajneeshees, followers of Bhagwan Shree Rajneesh, a self-proclaimed guru exiled from India, had moved into a ranch in rural Wasco County, taken political control of the small nearby town of Antelope, and changed its name to Rajneesh. Next, the cult sought to run the whole county by winning the local election in 1984.

  The amazing story of the Wasco County election scandal was revealed to the conference's riveted participants by Leslie L. Zaitz, an investigative reporter for The Oregonian, and Dr. John Livengood, an epidemiologist at the Centers for Disease Control. To win the county election, the Rajneeshees planned to sicken a good portion of the population in the

town of The Dalles, where most Wasco County voters live. Their weapon of choice to keep local residents from voting was salmonella bacteria. Cult members decided to test the use of salmonella and, if successful, to contaminate the entire water system of The Dalles on Election Day. First, the Rajneeshees poisoned two visiting Wasco County commissioners on a hot day by plying them with refreshing drinks of cold water laced with salmonella. Then, on a shopping trip to The Dalles, cult members sprinkled salmonella on produce in grocery stores "just for fun." According to reporter Zaitz, that experiment didn't get the results they wanted so the Rajneeshees proceeded to clandestinely sprinkle salmonella at the town's restaurant salad bars. Ten restaurants were hit and more than 700 people got sick.

Wasco County Sheriffs This history includes a recounting of the Rajneeshees involvement in this Oregon community

- News Database -

Database of archived news items
(Includes items added since Oct. 25, 1999. See about this database)
» See also the News Database for Osho

- See Also -

» Osho

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What's New

by Bob Park

The American Physical Society

Friday, 14 December 2001 Washington, DC

1. OLYMPIC TORCH RELAY: CONGRESSIONAL ACTION PUTS PHYSICIST IN.

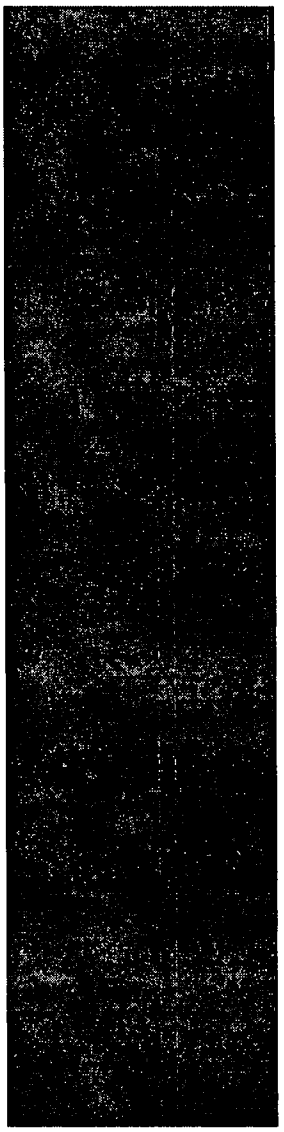
Having run out of mountains to climb (he did Everest in 2000), our own Francis Slakey, APS Associate Director of Public Affairs, will run a leg of the 2002 Winter Olympics Torch Relay starting on the East Steps of the U.S. Capitol at 3:16pm on 21 Dec. Post- anthrax security rules bar all public ceremonies from the Capitol Grounds, but, Congress took swift action, adopting a Concurrent Resolution that grants an exception for the Olympic Torch Relay.

2. ABM TREATY: BUSH DECLARES U.S. INTENT TO WITHDRAW IN 6 MONTHS.

At a time when the U.S. is desperately seeking the cooperation of other nations in its war on terrorism, the U.S. seems intent on getting out of agreements. We failed to ratify the Comprehensive Test Ban Treaty, bowed out of the Kyoto accord on climate change, walked out of the Geneva conference on biological weapons, and now, as he has threatened for months, President Bush formally gave six-months notice, as required, of our intent to withdraw from the 1992 ABM Treaty. Critics have argued that abandoning the 1972 treaty would lead to an arms race, but just hours after Bush's announcement, Colin Powell declared that "an arms race has not been set off." It could be too early to tell.

3. BIO-TERRORISM: LINKS TO THE HEAD OF A WHITE HOUSE COMMISSION?

Three New York Times writers, Judith Miller, Stephen Engelberg and William Broad have turned out an incredibly timely piece of investigative reporting at its best. Germs, Simon & Schuster, 2001, begins with a chilling account of the first bio-terrorism attack on U.S. soil: the deliberate salmonella poisoning of hundreds of residents in Wasco County Oregon in an effort to keep them away from the polls, and thus take political control of the region. The attack was carried out by members of a free-sex cult led by Bhagwan Shree Rajneesh, who was subsequently deported. What Germs doesn't tell you is that one of Rajneesh's followers was



a psychiatrist named James Gordon (WN 16 Aug 96), who wrote The Golden Guru, an admiring book about Rajneesh. Gordon was involved in the effort to take political control of Antelope, Oregon. Incredibly, James Gordon now heads the White House Commission on Complementary and Alternative Medicine Policy (WN 19 Oct 01), created in waning days of the Clinton Administration.

4. PCAST: BUSH NAMES ADVISORY COUNCIL ON SCIENCE AND TECHNOLOGY.

The co-chairs were already known, Jack Marburger, the President's Science Advisor, and Floyd Kvamme, a Silicon Valley venture capitalist. Most of the 24 members are from the information- technology industry. Unlike past Councils, there is virtually no representation from research scientists. Even the few academics best known as administrators. The sole exception is Charles Arntzen, a plant biologist from Arizona State University.

Bob Park can be reached via email at opa@aps.org

THE AMERICAN PHYSICAL SOCIETY and THE UNIVERSITY OF MARYLAND

Opinions are the author's and are not necessarily shared by the American Physical Society or the University, but they should be.

Click Here to View Sheriff List and Photos

Ernest D. Mosier followed Harold Sexton and was Sheriff of Wasco County two different times. He first served from 1953 to September, 1963, when he resigned. He came back to spend six more years as Sheriff from July 1971 to 1977 when he was appointed to replace the resigning William L. Bell.

A native of The Dalles, Mosier graduated from The Dalles High School and later attended Willamette University. Before joining the Sheriffs' Office, Mosier was an office manager at a number of companies in The Dalles area.

Sterling Arthur Trent was appointed to take Mosier's place when he resigned. A native of Gorin, Missouri, Trent served as Sheriff of Wasco County until June 1968, when he died in office. He moved to Oregon in 1913 and was a Deputy Sheriff from July 1954 until he was appointed Sheriff in September 1963.

A graduate of The Dalles High School, Trent worked in the construction business for a time and also managed a tire shop and was a stock rancher for a while. When Trent died, Grant Cyphers was appointed to take his place, but Cyphers served only a month before it was dis- covered he was of the wrong political party.

William L. Bell was appointed to take Cyphers' place and remained Sheriff of Wasco County until July 1971, when he resigned to take a job with the Board on Police Standards and Training. A native of Long Beach, California, Bell moved to Oregon in 1947.

Bell graduated from Wheeler County High School in Fossil and attended five terms at the University of Oregon and two terms at Oregon College of Education. He signed on with The Dalles Police Department in 1957 as an officer but left for two years to serve in the United States Army from 1958 to 1960. He remained with The Dalles Police Department until 1968, when he was appointed to take the place of Cyphers.

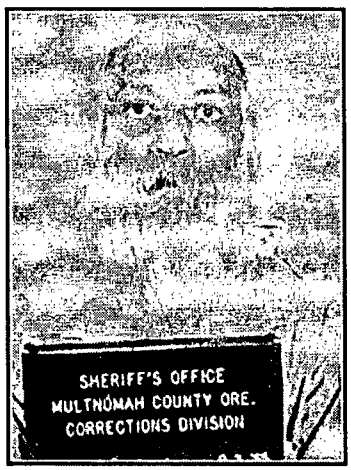
Ernest Mosier came back to serve as Sheriff when he was appointed to take Bell's place, remaining this time until 1977, when John B. Magill was elected. Magill-- whose family was an old ranching family in Wasco County -- served a four-year term before Robert G. "Bob" Brown was elected in 1981.

Born in Council Bluff, Iowa, Brown moved to Oregon in 1963 from South Dakota. He graduated from the University of Nebraska in Omaha in 1962 with degrees in business administration and

engineering. He worked for seven years as a superintendent and engineer for Peter Kiewet & Sons in Nebraska, South Dakota, North Dakota, Montana, Washington and Oregon. From 1967 until 1980, Brown worked for Tenneson Engineering in The Dalles.

Art Labrousse won the 1984 election and was re-elected in 1988 to become the first two-term Sheriff in Wasco County since 1968.

Big Muddy-ed Affair



In 1981, Wasco County school children learned a new word: Rajneeshees. Even before the start of the school year, a few lessons on this strange East Indian word and what it meant. Followers of the nomadic Indian guru Bhagwan Shree Rajneesh purchased the rambling, 64,229 acre Big Muddy Ranch in Wasco and Jefferson counties in July of 1981 as the central commune for the Bhagwan and his devoted followers.

At first, the residents of nearby Antelope viewed the sudden appearance of the red-clad Rajneesh disciples, known as Sannyasins but more commonly referred to as Rashneeshees, as nothing more than a curiosity. It wasn't long, however, before they realized the seriousness and full intentions of the Rajneesh movement, or "invasion," as some locals preferred to call it.

While the Bhagwan's chief aide Ma Anand Sheela was declaring the movement's plan to operate a simple farming commune in the desert, his other disciples were busy in the background developing grand plans for a huge resort city for up to 100,000 Rajneeshees.

Within a matter of weeks, construction began on a number of buildings within the newly-christened Rancho Rajneesh, including a shoppng mall, restaurant, a resort-like motel and commune service offices. In many cases, Bhagwan followers moved ahead without securing proper county building permits.

In the meantime, new recruits continued pouring into the desert commune -many of them wealthy European and American followers who were more than willing and able to finance the Bhagwan's movement.

But the Rajneesh movement began to falter in October 1981 when two months after arriving at Rancho Rajneesh, the Bhagwan applied to the U.S. Immigration and Naturalization Service for an extension of his visa. Immigration officials began a full-scale investigation into the activities of the religious sect, focusing on the guru's intent in coming to the United States and a pattern of suspect marriages between the U.S. citizen and foreign followers.

The investigation turned up information that the Bhagwan and his followers left India in the spring of 1981 owing the Indian government more than $6 million in unpaid taxes. An Indian tax court voided the Rajneesh organization's tax-exempt status and assessed millions of rupees (Indian currency) in back taxes.

But the movement forged ahead in the Oregon desert. In April 1982, Rajneeshees, voting as a bloc, managed to secure enough votes to take over the town of Antelope, which was renamed Rajneesh. They also voted to incorporate Rancho Rajneesh -- the former Big Muddy Ranch as the town of Rajneeshpuram.

With this newly-acquired power, Rajneesh leaders began making more demands on county and state leaders. They demanded access to records and reports by Wasco County officials pertaining to the commune and its activities. They also demanded state basic school support for the Rajneeshees' school, even though the state rejected the demand, saying public tax dollars go to support public schools, not private ones like the Rajneesh school.

But problems were just beginning for the movement. Over the next three years, Rajneeshee leaders were accused of the salmonella poisonings of hundreds of residents of The Dalles and some 500 persons filed suit against the sect. Sheela, along with two other disciples, were accused in a 1985 federal grand jury indictment of plotting the unsuccessful murder of the Bhagwan's private physician.

And the Bhagwan himself broke his own vow of public silence in September 1985 with a scathing attack on Sheela and a half dozen of her allies, claiming they had betrayed him and his followers and that they had stolen $55 million from the commune. An article in The Oregonian on Sept. 17, 1985, quoted the Bhagwan as saying Sheela "and her gang had turned my commune into a fascist concentration camp."

The Bhagwan's claims that militant Rajneeshees had been stockpiling assault weapons and had been engaged in illegal wire-tapping at the ranch touched off a multi-agency investigation into the alleged criminal activity which proved to be the beginning of the end for Rajneeshpuram.

On Oct. 23, 1985, a federal grand jury in Portland secretly indicted the Bhagwan Shree Rajneesh, Sheela and six other Sannyasins for immigration crimes. Two days later, a Wasco County grand jury returned indictments against Sheela and two others, charging them with the attempted murder of Swami Devaraj, the Bhagwan's personal doctor.

By that time, Sheela and about 25 of her followers had already fled the ranch to Germany.

But Rajneeshpuram was thrown into turmoil on Oct. 28, 1985 when the Bhagwan' s loyal followers feared he had been arrested in Charlotte, N.C., trying to flee immigration authorities on a privately-chartered jet bound for Bermuda.

At about the same time, word arrived from Germany that Sheela and two Rajneesh women had been arrested by West German police.

The Bhagwan was returned to Oregon to face a 35-count federal indictment for immigration-related crimes, although he initially pled innocent to all 35 counts. But as part of the plea-bargaining agreement with federal prosecutors, the Bhagwan on Nov. 14, 1985, agreed to plead guilty to two of the felony counts, to pay the court costs and to leave the United States.

The Bhagwan returned to India and promptly told reporters gathered at a New Delhi airport that the United States -the place he called a land of religious freedom and opportunity four years

earlier -- was "just a wretched country."

Within a week of his departure, thousands of former followers were leaving Rajneeshpuram in busloads. Within a month of their departure, residents of the former Antelope reclaimed their town -and its original name. But legal action against the Rajneeshees would continue for many years.

Sheela and 20 other disciples later were indicted on federal wire-tapping charges. Numerous civil suits were filed against the bankrupt religious sect, some of which still have not been resolved.

On July 22, 1986, Sheela was sentenced to up to 20 years in prison and ordered to pay a $400,000 fine after pleading guilty to state and federal charges which included masterminding a massive electronic eavesdropping system at Rancho Rajneesh, plotting the attempted murder of the Bhagwan's physician and plotting the salmonella poisoning of about 750 people in The Dalles.

For many Rajneeshees, the dream of carving a utopian Shangri-la out of the barren, Central Oregon desert ended long before Jan. 18, 1990-- the day Bhagwan Shree Rajneesh died in Ashram in Pune, India, at the age of 58.

For Wasco County Sheriff Art Labrousse, it was a rare learning experience -- one he says he will never forget.

"They were well organized," Labrousse recalls. Or at least, better prepared to take control of the tiny town of Antelope than local officials were prepared to stop them. Labrousse and his 13-Deputy force had their hands full trying to maintain law and order with the sudden invasion of thousands of red-clad Rajneeshees into Wasco County.

What made it so difficult, says Labreusse, was the cloak of secrecy which seemed to engulf Rancho Rajneesh.

"Few people actually knew what was going on out there," he said. Labrousse recalled the telephone call to his office on July 3, 1985, from someone at the ranch reporting a possible drowning in a lake on the ranch. Before he could summon the Wasco County medical examiner to the scene, LaBrousse received another call, this time reporting that a young man had been pulled from the lake and briefly revived. The man was taken to the medical center in Jefferson County, but died, Labrousse was told.

Since the attending physician, who was a Rajneeshee doctor, also was the assistant medical examiner for Sherman County, Labrousse was told by the state there was no need to call in the state medical examiner. No body fluid or any other evidence was obtained by the assistant medical examiner.

"They had a doctor who was an assistant medical examiner for Jefferson County -- he ruled the man's death was accidental drowning," Labrousse said.

Two days later, Labrousse was drinking coffee with an Oregon State Police officer in Antelope. "We were talking about the Fourth of July fire in The Dalles, caused by fireworks, when one of the Rajneesh peace officers from Antelope said, 'Well, we had a great fireworks show ourselves -- we cremated a boy who just died."

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Senate Agriculture, Nutrition and Forestry Committee
Chairman Tom Harkin, Senator for Iowa

Cover Page:

to: Michelle Chang

from: Peter R.

date: 1/2/02

The White House Commission on Complementary and Alternative Medicine Policy was created March 8, 2000, by executive order. The 2-year commission will ultimately report to the president on legislative and administrative recommendations for ensuring that US public policy maximizes the benefits of complementary and alternative medicine. In this column, the chair of the commission will offer his thoughts about the goals and work of this key advisory body.

INTERIM PROGRESS REPORT
SEPTEMBER 18, 2001

James S. Gordon, MD, and the White House Commission on Complementary and Alternative Medicine Policy
Modified for *Alternative Therapies in Health and Medicine*

James S. Gordon chairs the White House Commission on Complementary and Alternative Medicine Policy and directs the Center for Mind-Body Medicine in Washington, DC. He is the author, most recently, of *Comprehensive Cancer Care: Integrating Alternative, Complementary, and Conventional Therapies* (Perseus Press, 2000).

What follows is the White House Commission's interim progress report. It's a summary of what we've heard from 1000 people testifying in person and 2000 communicating to us in writing. There are no recommendations from the commission now. When you read the report you'll know where we've been and what we've seen and heard. Also, you'll have a good idea of where we're headed.

First, it's becoming increasingly clear that the commission is being moved by principle as well as practical considerations. We're as concerned with wholeness and uniqueness as we are with scientific evidence; with self-care and self-awareness as well as treatment; with the universal spirit of healing as well as specific therapies of the world's medicines.

There is, too, an understanding that the work of creating a new medicine and a new healthcare must be deeply collaborative and mutually respectful: complementary and alternative medicine (CAM) providers working alongside conventional clinicians; research methodology serving—not ignoring or violating—the integrity of traditional systems of healing; decisions about research and training, services and financing shaped by the public as well as by professionals; students from CAM accorded similar opportunities and respect to those offered to the conventional professions.

There is a pervasive feeling among commissioners that the poor should have access to what the well-to-do now pay for out of pocket. There should be funding of large-scale demonstration projects to assess the effectiveness and cost-effectiveness of a variety of CAM and integrative approaches for low-income people. The young in schools; elderly in clinics, senior centers, and nursing homes; the dying at home and in hospices—all should have access to learning about self-care and the benefits of CAM.

Finally, a structure needs to be established within the government to coordinate all CAM activities, to make sure they are widely accessible, to ensure the provision of authoritative information to all who need it, and to fulfill the promise of the recommendations the commission will make.

The commission took some long steps toward shaping these and other recommendations on October 4-6. We'll be working more on them at the December 6-7 meeting. All of our deliberations are available to comment on and work on with us. We'll present our final report to the president and Congress in March 2002. There will be clear, strong, and specific recommendations then and, we hope, a clear map of the healthcare world in which we'd all like to work and live.

The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) was established by Executive Order 13147 on March 7, 2000, to develop legislative and administrative policy recommendations that will maximize the benefits of CAM practices and products for the general public.

The president and Congress created the commission in response to the public's interest in and use of CAM modalities and approaches as well as a variety of self-care practices. The commission is charged with submitting a final report to the president and Congress by March 7, 2002.

This interim progress report provides a brief overview of CAM as well as the commission and its activities. It also discusses the commission's progress to date on developing recommendations around the 4 major topic areas outlined in the president's executive order. Individuals and organizations are encouraged to provide written comments on this interim progress report for consideration by the commission through its Web site or by letter to the commission staff.

THE COMMISSION'S CHARGE

The president's executive order charged the commission to consider 4 broad topics related to CAM:

- coordinated research to increase knowledge about CAM practices and products
- the provision to healthcare professionals of reliable and useful information about CAM that can be made readily accessible and understandable to the general public
- guidance for appropriate access to and delivery of CAM

• the education and training of healthcare practitioners in CAM

The commission's role is to recommend policies that ensure the public's health and safety when accessing CAM practices and products and the practitioners who offer them. The commission will also recommend strategies to increase the availability of authoritative information about the safety and efficacy of CAM practices, techniques, practitioners, and products.

OVERVIEW OF CAM

Definitions of CAM continue to evolve. CAM generally refers to modalities, practices, techniques, and systems of healing that are used together with ("complementary to") or instead of ("alternative to") conventional medicine. Among the modalities that are associated most often with the term *CAM* are chiropractic, acupuncture, massage therapy, mind-body techniques (eg, biofeedback, guided imagery, yoga, meditation), some forms of nutritional therapy, dietary supplements (including herbs), as well as homeopathy, naturopathic medicine, various forms of energy healing, and the indigenous healing systems of the many ethnic groups in the United States.

Over the past decade, several nationwide surveys have documented a substantial and growing usage of CAM practices and products by the American public.[1-4] These surveys have found that most CAM users seek out conventional medical treatment first, then turn to CAM practitioners. Most people appear to use CAM in conjunction with, not as a replacement for, conventional medical therapy, and many seek out care that integrates the best of a variety of approaches.[1] The use of CAM modalities, practices, and products by the general population varies in the published literature, ranging from 6.5%[5] to 42%,[1,6] depending on the population studied and the criteria used to define CAM. Other studies have documented even higher use of CAM therapies among people with chronic and life-threatening conditions.[7,8] For example, a recent study at a major cancer center indicated that 69% of patients included CAM approaches as part of their cancer care.[9]

AN OVERVIEW OF THE COMMISSION: ITS MEMBERSHIP AND ACTIVITIES TO DATE

Commission Membership

The commission includes 20 members representing a diverse range of expertise in biomedical research, medical, and CAM fields. The commissioners include the chair, James S. Gordon, MD; George M. Bernier, Jr, MD; David E. Bresler, PhD; Thomas M. Chappell; Effie Poy Yew Chow, PhD; George T. DeVries III; William R. Fair, MD; Joseph J. Fins, MD; Veronica Gutierrez, DC; Wayne B. Jonas, MD; Charlotte R. Kerr, RSM, RN, MPH, MAc; Linnea S. Larson, LCSW; Tieraona Low Dog, MD, AHG; Dean Ornish, MD; Conchita M. Paz, MD; Joseph E. Pizzorno, Jr, ND; Buford L. Rolin; Julia Scott; Xiaoming Tian, MD; and Donald W. Warren, DDS.

Activities to Date

The commission has held 7 formal meetings in Washington, DC, all of which have included sessions for open public comment, and 4 town hall meetings, where hundreds of people gave testimony. In total, the commission has heard from more than 1000 speakers and received nearly 2000 individual comments and recommendations from the public. In the coming months, the commission plans to review reports from previous commissions and authoritative bodies on the topics identified in its charge and to solicit additional written comments and suggestions from the general public by e-mail, fax, and mail.

Each of the commission meetings has focused on 1 or more of the 4 major topics in the presidential executive order, as follows:

• July 13-14, 2000: Planning Meeting

• October 5-6, 2000: Coordination of CAM Research

• December 4-5, 2000: Access and Delivery of CAM Services and Products

• February 22-23, 2001: Education, Training, and Credentialing for CAM Practices

• March 26-27, 2001: Wellness, Self-Care, and Prevention, and the Development and Dissemination of CAM Information to the Public

• May 14-16, 2001: Coverage and Reimbursement of CAM Services and Coordination of CAM Research

• July 2-3, 2001: Discussion of the Interim Progress Report and Draft Recommendations

At the 4 town hall meetings held in San Francisco, Seattle, New York City, and Minneapolis, testimony was presented on subjects related to all 4 topics. The transcripts, agenda, and other information pertaining to all commission meetings and town hall meetings are available on the commission's Web site, http://whccamp.hhs.gov. Additional information such as commissioner biographies and a schedule of future meetings also is readily available at the Web site, which is periodically updated to reflect ongoing activities. Comments, recommendations, and suggestions can be sent through the Web site or e-mailed to whccamp@mail.nih.gov.

The Commission's Progress to Date

The commission supports the promotion of rigorous science and the appropriate use of the scientific method in research studies. The commission recognizes the major ongoing contributions in this area by the National Center for Complementary and Alternative Medicine (NCCAM) at the National Institutes of Health. The commission also supports making the current evidence for CAM practices and products more widely and easily available to the public and healthcare providers. The commission recognizes that recommendations in the final report about the appropriate use of safe and effective CAM practices and products must be grounded in sound scientific and ethical principles.

Other principles that will guide the commission in its deliberations include an emphasis on health promotion and wellness in addition to disease prevention and the treatment of illness; a recognition that the body has a remarkable capacity for healing that can be facilitated by addressing the underlying causes of illness and suffering; an attention to all aspects of life that can impact health—physical, mental, emotional, environmental, and spiritual; an understanding that each person has unique needs that must be attended to in every therapeutic setting and encounter;

and a belief that self-care is integral to our nation's healthcare and should be taught to health professionals and the public.

The commission also is focused on maximizing the potential benefits of CAM by considering recommendations that promote collaborations between conventional and CAM healthcare professionals and researchers, and by encouraging the integrated delivery of CAM along with conventional medicine, where appropriate. Furthermore, the commission recognizes that consumers have a basic right to choose freely among qualified CAM practitioners and safe products they believe are beneficial to their health, and must be included as partners in any policy or regulatory decisions about CAM access, delivery, and research.

The commission's recommendations will be formed by the evidence presented and gathered during its deliberations. The diverse perspectives reflected in the testimony heard from advocates, critics, and other expert witnesses will be considered in the context of these principles and the potential benefits and risks of CAM use in this country. This interim report provides an overview of the issues presented to the commission, including the need for federal efforts to ensure access by the public to safe and efficacious CAM services and products, and for reliable and timely information.

A number of speakers noted that many CAM systems of practice place an emphasis on promoting wellness in addition to treating illness and dysfunction. There was considerable public support for the federal government to help shape health promotion initiatives and disseminate information to the public on CAM as well as conventional approaches to wellness and disease prevention.

COORDINATION OF CAM RESEARCH

Americans are seeking out and using CAM practices and products. In many cases, people are using these practices and products without the scientifically based information necessary to make informed choices about their safety and efficacy. Individuals who testified from both the CAM and conventional medical communities agreed that the public's health and safety calls for more rigorous scientific research and more readily available information on the results of CAM research that already exist. Underlying all research is the paramount goal of producing dependable and relevant information for practitioners and the public.

Testimony to the commission described a growing interest in and support for CAM research, not only on the part of the CAM community and the public, but also at the federal level, in academic health centers, in community hospitals, and in mainstream private practices. This interest has further stimulated CAM professional schools and manufacturers of CAM products to enhance their own research capacity. The National Institutes of Health research institutes and centers, including the NCCAM, plan to fund more than $220 million for CAM research and research training in FY2002. The importance of public input into the research agenda was discussed often during testimony.

Speakers identified several types of evidence-based medical research they believe is needed, such as studies on the basic mechanisms of action, clinical safety and efficacy, treatment outcomes, and health services including cost-effectiveness and healthcare delivery. Speakers and commissioners agreed that to be methodologically sound, CAM-related studies must have a clear question (hypothesis); a sound study design; a qualified research team; objective, verifiable data; and balanced conclusions that meet acceptable standards of evidence. There was general agreement that the research should meet high standards of design and execution consistent with the type of information being sought; that strategies be applied that appropriately incorporate step-wise approaches to research sequence and design, as is done in many areas of conventional medical research; and that clinical research comply with human subject protections and appropriate institutional review board guidelines.

Many of those who testified agreed that CAM research might be best served by collaborations between conventional and CAM researchers and clinicians. One goal of these collaborations is to produce research results that meet the rigorous publication requirements of published and online peer-reviewed journals that already set standards for the conventional medical community. Testimony also emphasized the need for continued support for training conventional and CAM researchers to study CAM therapies, increased support for developing research infrastructures at accredited CAM and conventional institutions, and developing funding initiatives to study promising nonpatentable products.

Support and coordination of CAM activities by agencies of the federal government were seen as essential to ensure the types and quality of studies needed as key elements in achieving research progress in these areas. Numerous speakers identified strong and continued support for agencies involved in CAM research and related activities and support for all other federal agencies with research or related responsibilities. In addition, there was considerable public support for encouraging the private sector—foundations, product manufacturers, and pharmaceutical companies—to support CAM research and collaborate with the federal sector in strengthening research efforts.

Regulatory Activities

Effective regulations serve and protect the public by ensuring compliance with standards that are shaped by good research, and removing harmful products from the marketplace. Public testimony supported the importance of the federal government's role in ensuring that CAM products are safe. Testimony also expressed concern that the content and purity of some CAM products, such as dietary supplements, are inconsistent and could potentially have negative health consequences. Testimony indicated that the US Food and Drug Administration (FDA) has authority, through the Dietary Supplement Health and Education Act (DSHEA), to ensure product safety, but FDA's resources have not been commensurate with these responsibilities. In the testimony, there was strong support to fully implement DSHEA, provide adequate

funding for its full implementation, and ensure that the FDA has adequate professional staff with expertise in dietary supplements, particularly botanical products.

A number of speakers, including many from the dietary supplement industry, asked that the FDA establish regulations on good manufacturing practices, or GMPs, for quality control and guidelines on processing and production as approaches to ensuring the safety and integrity of all products during manufacture. They also called on federal agencies and the private sector to coordinate efforts to establish and implement guidelines standardizing the composition and purity of products, and to address possible contaminants and adulterants. Researchers asked for standards that will result in a readily available supply of products with consistent composition to ensure reliable research results. There was also support for the establishment of a dedicated CAM-related office and/or CAM-related core review teams to facilitate the regulatory review of CAM products.

Although the number of adverse events reported from the use of dietary supplements is relatively small, any adverse event can become a public health issue. Several speakers asked for a strengthening and expansion of the FDA's adverse event reporting (AER) system and for this information to be made widely available. This is consistent with a recent report from the Office of the Inspector General of the Department of Heath and Human Services that describes the current limitations of the AER system for all products and provides recommendations to improve it.[9]

Testimony focused on the need for manufacturers to make information on the benefits and risks of herbs and dietary supplements readily available to consumers and healthcare professionals through methods such as improved labeling, package inserts, and information at points of sale. This information should include any limitations; known interactions with drugs, foods, and other health products; and possible risks to vulnerable populations, including children, the elderly, pregnant and nursing women, and those with certain health conditions or compromised immune systems.[10]

PROVIDING RELIABLE, USEFUL INFORMATION ON CAM TO HEALTHCARE PROFESSIONALS AND THE PUBLIC

The commission heard testimony that the quality, accuracy, accessibility, and timeliness of information on CAM practices and products vary greatly, and there is a significant need for accurate, authoritative, and up-to-date information about CAM. People want to know which CAM approaches might work for them, where they can find professionals qualified to provide these services, and how CAM therapies might interact with their conventional treatments. Clinicians, likewise, need information on the safety and efficacy of various CAM approaches so that they can converse with their patients about CAM and make appropriate and authoritative recommendations and referrals.

Internet, Radio, Television, and Print Media

The Internet has emerged as a major source of healthcare information, including information related to CAM, for both consumers and healthcare providers. The Federal Trade Commission (FTC) predicts that 30 million Americans will seek health information online in 2001, and that this number is increasing dramatically.[11] There are numerous CAM-specific Web sites as well as a variety of general health information sites that include some CAM information. According to public testimony, some of these sites provide accurate and current information, whereas many others contain inaccurate, misleading, self-serving, or outdated information.

The commission heard that for people without access to the Internet or the skills to use the Internet, the National Library of Medicine and the public libraries, through the American Library Association, are training librarians to help people gain access to health information on the Internet. It was suggested that these efforts also could be used to help people gain access to information on CAM practices and products.

Similarly, the commission heard testimony that television, radio, and print media coverage of CAM benefits and safety issues is often uneven, incomplete, or biased. Media representatives, health professionals, and the general public said that several federal agencies provide important and useful resources for information on the benefits and safety of CAM. However, they said they are still hampered in their efforts to obtain objective, comprehensive information about CAM by the lack of a central, authoritative resource within the federal government that can quickly and reliably answer questions on a variety of CAM issues.

Many people from the conventional and CAM professional communities, the public, and the media asked the federal government to assume a greater leadership role in providing and coordinating authoritative information about CAM practices and products in an easily accessible form that ensures consistent, quality information.

Public testimony described indigenous systems of healing and the use of culturally based CAM therapies among people of different racial and ethnic groups. Community leaders called for the development and promotion of information on the appropriate use of CAM therapies that would be targeted to diverse population groups in the United States.

Public testimony suggested that the federal government establish a public education campaign that teaches consumers how to evaluate and assess information on treatments that have not been evaluated by the FDA. It also was suggested that a public-private partnership be created to establish a voluntary code of standards for information available on the Internet and through other media, including standards for ethics and disclosure of conflicts of interest.

Advertising, Marketing, and Labeling Regulatory Activities

Advertising, marketing, and labeling are important mechanisms for disseminating information to the public about products. The commission heard testimony that there is a significant amount of false and misleading advertising, marketing, and labeling of CAM products and practices, especially herbal and dietary supplements. Of particular concern is the marketing of products or services that may be unnecessary, harmful, or otherwise detrimental to the general public, including low-income

populations, the elderly, and non–English-speaking people. False and misleading advertising may lead people to seek treatments that are not only costly, but also may delay or interfere with more appropriate or effective treatments.

The commission heard about the role of the FTC in identifying false and deceptive CAM-related health claims, and its efforts to minimize the occurrence of these claims. There was public support for sufficient resources for federal agencies such as the FTC and the Consumer Product Safety Commission to improve oversight of CAM products and services. Testimony also underscored the need for increased consumer education in identifying deceptive and unsubstantiated claims in all forms of marketing and advertising, and the importance of involving trusted community leaders in developing successful strategies to prevent consumer exploitation.

ACCESS TO AND DELIVERY OF CAM

Access to and delivery of healthcare services affect healthcare utilization and health outcomes. Many factors influence access to and delivery and use of healthcare services. These factors may include quality of care; distribution and availability of local providers; licensing, certification, and credentialing of providers; coverage and reimbursement; characteristics of the healthcare delivery system; and consumer outreach, education, and satisfaction. The commission heard testimony that, as with conventional care, these factors often are more problematic for rural, uninsured, underinsured, and diverse populations.

Consumers, healthcare professionals, and representatives of professional organizations and educational institutions told the commission that Americans want to be able to choose from conventional and CAM practices and products, and they want assurances that practitioners are qualified and products are safe. According to testimony, many Americans have neither this choice nor these assurances.

Testimony described how states regulate healthcare practitioners by helping to assure quality and accountability of professions and providing a process for professional conduct review and disciplinary action. Information provided to the commission illustrates state-by-state variability in regulatory approaches to licensure and scope of practice. This information shows that chiropractors are licensed in all states, whereas acupuncturists, massage therapists, and naturopathic physicians are licensed in 40, 30, and 11 states, respectively. These variations impact access to and delivery of CAM by limiting practitioners' ability to practice lawfully and obtain malpractice insurance.

Although some CAM professions endorse licensure and certification to participate more fully in the healthcare delivery system, several witnesses testified that licensure or certification is not feasible for some categories of CAM practitioners such as Native American and other traditional healers. Some CAM practitioners consider their disciplines to be educational (Alexander Technique) or spiritual (Reiki) and have expressed concerns about licensing as health professionals. The commission also heard from several conventional practitioners who incorporate CAM modalities in their practices and are concerned

that their integrative approach does not lend itself to the licensure process. Some, but not all, of the conventional practitioners who testified recommended that scope of practice laws be broadened to allow latitude for CAM modalities to be used.

The commission heard about several models of delivery of CAM services. These included solo CAM practitioners; free-standing CAM facilities offering multiple CAM approaches; collaborative models that support referrals, consultation, and comanagement; and a variety of integrative models in which CAM practitioners work with conventional practitioners. There has been little evaluation of the effect on access, clinical outcomes, or cost-effectiveness of these models.

Whereas many of those testifying supported integrative models of delivery, a perspective of some CAM practitioners was that the integrity, philosophy, and standards of CAM disciplines may be compromised, and the effectiveness of CAM practices may be diminished or lost, as various integrative approaches are explored. Other CAM practitioners suggested that if integration occurs, it should include entire systems of care and healing rather than only selective incorporation of CAM modalities that fit into the biomedical model. The importance of educating conventional practitioners in the philosophical and historical roots of CAM disciplines was cited as an important step in preserving the integrity of these other systems of care and healing.

Testimony indicated variation in use of CAM among people of different racial, ethnic, and cultural backgrounds, as well as geographic, economic, and condition-specific variations. However, testimony provided little information regarding factors that determine consumer choice of CAM practices and products. Obtaining this information is important in the appropriate design, development, and implementation of policies and programs.

Coverage and Reimbursement of CAM Practices and Products

The commission heard from a spectrum of experts on healthcare financing, the insurance and managed care industries, and other issues regarding coverage and reimbursement of CAM practices and products. Employers and other health plan sponsors are the major purchasers of health coverage and, in conjunction with insurance companies and managed care organizations, they determine which health benefits are covered and how the services are reimbursed for most Americans.

Testimony indicated increasing interest in and coverage of CAM services by employer-sponsored health plans in direct response to employee requests. They also are increasingly adding CAM benefits to attract and retain employees, improve health, and comply with state mandates. Various employer-sponsored health plans were described, including limited coverage for certain CAM services (eg, chiropractic care) as part of a basic benefit package; information-only programs (eg, Internet-based programs related to CAM modalities); on-site services (eg, yoga classes); a CAM benefit account (eg, a $500 annual maximum benefit, with employee copayments); discount programs (employees may receive CAM services and pay a discounted fee by using a prescreened panel of CAM providers); or benefit riders (employees may opt to participate in a CAM managed care plan that offers certain services through a credentialed network of CAM providers and with utilization controls).

Federal and state governments are also major purchasers of healthcare. The federal government, often through congressional legislation, makes decisions regarding the health benefits for Medicare, Medicaid, the military, veterans, federal employees, and others, including funding for the State Children's Health Insurance Program. Some federally sponsored sites, such as military and veterans' treatment facilities, are beginning to make some CAM benefits available. States establish health plans for their employees and share responsibility with the federal government for the Medicaid program and the State Children's Health Insurance Program. States usually enhance the federally mandated benefits available under Medicaid and extend Medicaid coverage to the medically indigent.

Despite such programs, an overwhelming majority of Americans do not have coverage or reimbursement for CAM services or products. They must pay out of pocket for CAM treatment of diseases and for prevention and wellness services. Therefore, access to CAM products and practices appears to be limited largely by the ability to pay. Other witnesses noted that limited access to CAM practices and products is part of the larger problem of limited access to all healthcare.

Representatives of the insurance and managed care industries told the commission that they are interested in adding covered benefits provided that the services and products are safe, of consistently high quality, are no longer investigational, and that criteria exist for determining medical necessity. They also want standards of practice to guide utilization, assure quality care, and manage financial risk (in view of the potential for malpractice/medical liability suits). Another requirement they specified is that practitioners are adequately educated, trained, and qualified by licensure and/or certification.

Those healthcare purchasers who are interested in offering CAM services often must base their decisions on incomplete information on safety, efficacy, and cost-effectiveness. They also expressed a strong interest in research on determining whether CAM services and products would be replacements for or additions to conventional services and products. Purchasers testifying before the commission identified a need for the development of appropriate coding for CAM services, improvement of the collection of claims data, and the development of databases for managing information and conducting research on the cost-effectiveness and use of CAM. It was suggested that public agencies and private organizations cosponsor conferences on the development of data on CAM services and products to address issues of coding and building claims databases, and to identify what decision makers need regarding utilization and cost information.

Public testimony recommended that health services research and demonstration projects be funded by public, private, and joint public-private sources to provide information on the efficacy, cost-effectiveness, and cost benefits of CAM practices

and products. It was also requested that the federal government establish and adequately fund efforts to make CAM research results more available and accessible to the public and to industry, particularly employers, insurers, and policy makers at the federal and state levels.

THE EDUCATION AND TRAINING OF HEALTHCARE PRACTITIONERS IN CAM

Testimony underscored the importance of increasing the knowledge and understanding of CAM among conventional healthcare practitioners to enhance and protect the public's health. It was suggested that a basic or core CAM curriculum for conventional healthcare professionals be developed at the professional schools, in postgraduate training programs, and at continuing education programs. It also was suggested that these curricula in CAM fundamentals and principles should be developed in conjunction with CAM experts. The curricula should establish, to the extent possible, an evidence-based foundation for conventional health professionals to discuss CAM use with their patients, make referrals to appropriately trained CAM professionals, and develop an understanding of the interactions, either therapeutic or harmful, between conventional and CAM treatments to improve and safeguard their patients' health.

Consumer testimony revealed that many people are reluctant to disclose their CAM use to their conventional healthcare providers whom they believe are not knowledgeable about CAM or interested in CAM approaches to healing. This represents a potential health hazard because conventional practitioners often do not know that their patients may be taking dietary supplements or using CAM practices and products that may interact with medical treatments[8,12,13] or perioperative care associated with anesthesia or surgical procedures.[13-15]

Another issue that emerged during testimony was the need to educate CAM practitioners in the basics of conventional healthcare so they can recognize the limits of their clinical expertise and potential complications of their interventions, and make appropriate referrals to conventional healthcare providers. It was suggested that a basic curriculum for CAM students and practitioners should include information about evidence-based conventional medicine, conventional healthcare, and other CAM modalities and systems of healthcare. The commission learned about innovative models of cooperative and collaborative CAM training programs that expose conventional medical and CAM students to each other's philosophies and practices. Continuing education programs exist for audiences composed of both conventional and CAM practitioners.

A number of CAM representatives reported that there is a need for access to funding and other resources for faculty, curricula, and program development as well as for student access to loan and scholarship opportunities. Testimony also suggested that training of CAM professionals should include high-quality postgraduate and continuing education programs that resemble those currently available to conventional healthcare providers.

COORDINATING AND CENTRALIZING FEDERAL CAM EFFORTS

The commission heard testimony recommending a centralized process at the federal level to coordinate CAM activities to ensure optimal access to safe and effective CAM products, services, and modalities. The commission will continue to consider a range of administrative options to promote this level of coordination, including the creation of a centralized federal office. The Office on Women's Health, or the Office on Minority Health, both established within the Office of the Secretary for Health and Human Services, may provide useful models from which the commission can develop an operational proposal. These offices primarily serve to coordinate, support, and enhance ongoing and new federal efforts relevant to their missions at all levels of the federal sector. Therefore, a centralized coordinating entity for CAM would neither preempt nor supplant those federal efforts already in place, particularly the research activities or agenda of the NCCAM. Nor would it supplant the responsibilities of regulatory agencies such as the FDA and the FTC.

CAM IN WELLNESS, SELF-CARE, HEALTH PROMOTION, AND DISEASE PREVENTION

The role of CAM in wellness, self-care, health promotion, and disease prevention was a frequently emphasized topic throughout the testimony provided to the commission, including areas where CAM may assist in achieving the nation's health promotion and disease prevention goals. Since the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease* in 1979, goals and objectives for the nation's health have been defined and monitored. The most recent report, *Healthy People 2010*, includes the involvement of all of the agencies within the Public Health Service as well as state and local health departments and a wide range of private sector health organizations. Witnesses testified that the integration of CAM in health promotion and disease prevention could have profound positive consequences for the wellness and quality of life of individuals, and may impact on the healthcare delivery system of the United States.

Many CAM disciplines are derived from cultural traditions and practices that are rooted in connections between the body, mind, and spirit and between individual health and the community's well-being. Public testimony recommended that CAM principles and practices of health promotion be taught at all levels of the educational system, and that methods be explored to integrate CAM principles (eg, connection of body, mind, and spirit) and practices (eg, stress reduction techniques, nutrition) into a national health and wellness initiative.

In the testimony presented to the commission, the current healthcare system was described as primarily disease-focused, with most of research, education, training, reimbursement, and information development and dissemination directed toward identifying and treating diseases and conditions. Some who testified believe that the incorporation of CAM principles and practices into the current healthcare system would improve the emphasis on wellness, self-care, health promotion, and disease prevention. Many feel that one of the most important and enduring contributions of CAM will be its emphasis on maintaining wellness and the important role of self-care.

Witnesses described programs in schools, the workplace, geriatric centers, and other institutions that are integrating CAM approaches to wellness, self-care, and prevention into their activities, and recommended that these programs be studied and expanded. It was also emphasized that conventional health professionals need to have some training in the role of CAM in wellness, self-care, and prevention, and that a multidisciplinary team approach, with CAM and conventional providers working together, may be a very effective way to promote health and enhance self-care and wellness.

CONCLUSION

The commission continues to deliberate on all of the issues discussed in the interim progress report and others to fully comply with the executive order. The commission continues to study working models from many sources, including those from other countries. The final report will provide detailed recommendations regarding the 4 topics identified in the executive order: coordinating research on CAM, providing access to and delivery of CAM practices and products, developing and providing reliable information on CAM, and educating all healthcare practitioners in CAM. The recommendations will reflect principles that guide good healthcare, promote sound scientific inquiry related to CAM, maximize access and delivery of safe and efficacious healthcare, and promote health and prevent illness by encouraging the well-being of the whole person. As the commission develops final recommendations and proposals for legislative and administrative actions, it will continue to solicit and consider the advice of the public.

References

1. Astin JA. Why patients use alternative medicine: results of a national study. *JAMA*. 1998;279:1548-1553.
2. Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco TL. Unconventional medicine in the United States: prevalence, costs, and patterns of use. *N Engl J Med*. 1993;328:246-252.
3. Eisenberg DM, Davis RB, Ettner SL, et al. Trends in CAM use in the United States 1990-1997: results of a follow-up national survey. *JAMA*. 1998;280:1569-1575.
4. Paramore LC. The use of alternative therapies: estimates from the 1994 Robert Wood Johnson Foundation National Access to Care Survey. *J Pain Symptom Manage*. 1997;13(2):83-89.
5. Druss BG, Rosenheck RA. Association between use of unconventional therapies and conventional medical services. *JAMA*. 1999;282:651-656.
6. Fairfield KM, Eisenberg DM, Davis RB, Libman H, Phillips RS. Patterns of use, expenditures, and perceived efficacy of complementary and alternative therapies in HIV-infected patients. *Arch Intern Med*. 1998;158:2257-2264.
7. Rao JK, Mihaliak K, Kroenke K, Bradley J, Tierney WM, Weinberger M. Use of complementary therapies for arthritis among patients of rheumatologists. *Ann Intern Med*. 1999;131:409-416.
8. Richardson MA, Sanders T, Palmer JL, et al. Complementary/alternative medicine use in a comprehensive cancer center and implications for oncology. *J Clin Oncol*. 2000;18(13):2501-2504.
9. Office of Inspector General, Department of Health and Human Services. *Adverse Event Reporting for Dietary Supplements: An Inadequate Safety Valve*. Publication #OEI-01-00-00180. April 2001.
10. Blendon RJ, DesRoches CM, Benson JM, Brodie M, Altman DE. Americans' views on the use and regulation of dietary supplements. *Arch Intern Med*. 2001;161(6):805-810.
11. Federal Trade Commission. *Protecting Consumers Online: An FTC Report on the First Five Years of Its Internet Law Enforcement Program*. December 1999.
12. Piscitelli SC, Burstein AH, Chaitt D, Alfaro RM, Falloon J. Indinavir concentrations and St John's wort. *Lancet*. 2000;355(9203):547-548.
13. Fugh-Berman A. Herb-drug interactions. *Lancet*. 2000;355:134-138.
14. Ang-Lee MK, Moss J, Yuan C. Herbal medicines and perioperative care. *JAMA*. 2001;286:208-216.
15. Baede-van Dijk PA, van Galen E, Lekkerkerker JF. Drug interactions of Hypericum perforatum (St. John's wort) are potentially hazardous [review]. *Ned Tijdschr Geneeskd*. 2000;144(17):811-812. Dutch.

AUGUST NACCAM MEETING

Michael Muscat

Concept clearances ranging from the use of cranberry for urinary tract infection to a proposal for the new International Collaborative Research Program (ICReP) comprised the lion's share of the eighth meeting of the National Advisory Council for Complementary and Alternative Medicine (NACCAM), held August 27 at the Neuroscience Conference Center in Rockville, Md. Once approved, concept clearances are fashioned by National Center for Complementary and Alternative Medicine (NCCAM) program officers into requests for application (RFAs), program announcements (PAs), or other official research initiatives, depending on the nature of the proposal.

Other highlights of the meeting included presentations by Claude Lenfant, MD, director of the National Heart, Lung, and Blood Institute (NHLBI), and Drs James S. Gordon and Stephen Groft, the chair and executive director, respectively, of the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP), who discussed the WHCCAMP's soon-to-be-released interim report (see **White House Commission Report**, pp 32-40).

In addition, the NCCAM's director of extramural research, Richard Nahin, MPH, PhD, updated council members on the status of all complementary and alternative medicine (CAM) research initiatives approved by the NCCAM through May 2001. The open portion of the meeting ended with a brief period of council-initiated discussion.

OPENING REMARKS AND DIRECTOR'S COMMENTS

Taking place just 2 weeks before the September 11 terrorist attacks on the World Trade Center and the Pentagon, this was the last full council meeting of 2001. (Cancellation of a proposed October meeting had been announced previously.) NCCAM Director Stephen E. Straus, MD, reaffirmed the "strong support for NIH research" by the Bush Administration, which has recommended a $100.1 million budget for the NCCAM for FY02.

Dr Straus also praised the "actions and words" of Department of Health and Human Services (DHHS) Secretary Tommy Thompson, who had spent 4 days during the previous week "visiting the troops" at the NIH, even meeting with an NCCAM briefing team that included Drs Straus, Nahin, Kinsel, Camille Hoover (the center's executive officer), and others. At one point Secretary Thompson commented on Native American sweat lodges and asked about NCCAM research on St. John's wort and other herbal treatments.

"[Secretary Thompson] is highly enthusiastic about our charge," said Dr Straus. Hinting at one of the present meeting's concept clearance proposals, Dr Straus evoked the former governor's home state of Wisconsin, whose No. 1 fruit crop is the cranberry. "It's great to be ahead of the curve," he joked—a reference to the proposed initiative on the use of cranberry for treating urinary tract infection. (For more on Secretary Thompson's visit to the NIH, go to http://nccam.nih.gov.)

The meeting was officially opened by Jane Kinsel, MBA, PhD, the NACCAM's new executive secretary. Dr Straus welcomed Dr Kinsel and made announcements about several new NCCAM staff. Before turning to the composition of the NACCAM, he introduced Dr Martin Goldrosen, the center's new chief of scientific review, as well as Chris Thomsen, its new director of communications and public liaison (who was absent from the meeting). Dr Marc Blackman's first recruit for the NCCAM's fledgling intramural program, Dr Patrick Mansky, also was introduced. (See shaded box on page 27 for more about NCCAM new hires.)

Calling council members "special government employees," Dr Straus added that whereas most of the Bush Administration's hiring freezes had been lifted, they had created challenges and postponed approval of new council members named to replace the 5 members who rotated off council in July. "Drs Rhoades and Lawrence have agreed to stay on and extend their 'tours of service' during this interregnum," he said.

In light of the recent passing of Purdue University's Varro Tyler, PhD, ScD (see **News Briefs**, page 42), the renowned professor of pharmacognosy and widely recognized authority on herbal products, Dr Straus extended his condolences to Connie Weaver, PhD, an ad hoc member joining the council from Purdue. The NACCAM also was joined by ad hoc members Michael Irwin, MD, of the University of California–San Diego; Murray Goldstein, DO, MPH; Brian M. Berman, MD; and Zang-Hee Cho, PhD. It was announced that William R. Fair, MD, would join the meeting via telephone.

VIEW FROM THE NHLBI

In an informative presentation by Dr Claude Lenfant, director of the NHLBI, council members were treated to a short history of the institute and its mission, and were kept abreast of current CAM initiatives there, including mind-body research that has revealed the following:

- exaggerated systolic blood pressure reactivity (≤20 mm Hg) to stress is associated with an increased likelihood of stroke within the next 10 years
- hyperactivation of specific areas of the brain during mental stress is observed in coronary heart disease (CHD) patients compared to healthy subjects

the established asthma research community might yield more satisfactory results.

COL (Ret) James E. Williams, Jr, a public member of the council, asked about the role of patient advocates in NHLBI decision making. Dr Lenfant assured him that such organizations provide regular input, meeting with NHLBI officials annually.

WHITE HOUSE COMMISSION'S INTERIM REPORT

Stephen Groft, PharmD, and James S. Gordon, MD, were next to address the council. As the executive director and chair, respectively, of the WHCCAMP, they discussed the commission's much-anticipated interim report, sent to DHHS Secretary Thompson several weeks earlier. Dr Groft emphasized the preliminary nature of the report, stressing that it did not contain formal recommendations, but conveyed a sense of "what the commission has been thinking." Dr Gordon concurred, adding that it synthesized oral and written testimony from more than 3000 people who had communicated with the WHCCAMP and its staff since the commission's March 2000 inception.

"One area we've heard a lot about is the importance of establishing a mechanism for developing this field and moving it forward," said Dr Gordon. "We've heard from a number of institutions on education and training: there's a clear mandate for more education about CAM for everyone at every stage of training." He also acknowledged NCCAM efforts to encourage training and speculated about how that might be "stimulated on the postgraduate level."

The WHCCAMP's chair also spoke to issues of access and delivery of CAM products and services, as well as to current limitations on information. "There are not many models of successful integrative practices," he lamented. "We want to encourage the development of such models, perhaps in the form of health services research. There's a willingness among major insurers, for example, who are essentially saying 'help us figure out how to do demonstration programs.'"

Issues ranging from the coordination of federal-private research to coverage and reimbursement, as well as wellness, self-care, health promotion, and disease prevention would be addressed in the interim report, said Dr Gordon, even if only glancingly. He invited those present at the meeting—NCCAM staff, advisory council members, members of the press and the public—to attend the WHCCAMP meeting October 4-6, where commissioners would be "focusing on making draft recommendations for the final report."

Dr Goldstein raised the issue of human population laboratories for reaching target populations such as the elderly, many of whom live in organized retirement villages. "As in the Framingham study," he said, "there could be observing without interfering. [These methods] are expensive and take a long time, but if we don't do it as a national endeavor, it probably will never be done."

Council member William Meeker, DC, MPH, expressed concern about how the term *integration* was defined by the commission and followed up by asking Drs Groft and Gordon what kind of impact they believed the final report would have.

"Things don't happen all at one time," said Dr Groft. "We'll make perhaps 20 to 30 recommendations, but consult with various advisers and stakeholders about the feasibility of those recommendations first." He stressed that it "takes time to implement things," but evoked the "growth and willingness to change" that had developed over the past 10 years, making him optimistic about the future.

Citing "receptiveness" from people in the administration and in Congress, Dr Gordon shared his hopes that the WHCCAMP's work might continue to "feed what the NCCAM and other ICs (institutes and centers) are doing." Dr Straus invited Drs Groft and Gordon to return to the NACCAM's May 2002 meeting, after the commission has disbanded on March 7. That, said Dr Straus, would allow them both "time and space" to reflect on the commission's achievements.

UPDATE ON NCCAM INITIATIVES

In his presentation, Dr Nahin provided summary data on NCCAM initiatives beginning with August 1999 and ending with May 2001. Of the more than 20 initiatives developed over that period, most have focused on training/education and cancer treatment, with about half of the initiatives categorized as "mixed."

Ten education project grants have received NCCAM funding thus far, 2 more on traditional and indigenous medicine, another 2 on CAM clinical research, 4 on the development of natural products, and 5 supplementing research conducted by the National Cancer Institute. According to Dr Nahin, more than 60% of questions directed to the NCCAM Clearinghouse are cancer related. He called this "one of the prime reasons" for development of the Office of Alternative Medicine in the first place.

Dr Goldstein proposed that a number of mechanisms could be used to develop research initiatives, then asked how the NCCAM staff went about determining whether to use PAs or RFAs when conceptualizing their proposals. Dr Nahin cited budgetary and scientific concerns as key, noting that with PAs, in which applications were spread out over several fiscal years, there were no funds set aside.

"When the scientific questions are broader," explained Dr Nahin, "the PA mechanism is better, because there is more initiative allowed by the applicant community." However, he said, those proposals involving specific outcome measures—such as the chelation trial—are better off using RFAs: the applicant community can more easily be directed through the process. Requests for proposal, he said, are preferable when contracts are involved.

CONCEPT CLEARANCES

Following are brief summaries of the 4 concept clearances presented to council at this meeting. Whereas all initiatives were ultimately approved, some inspired more debate and discussion than did others. An idea of the primary issues and concerns raised by NACCAM members is provided.

Cranberry (*Vaccinium macrocarpon*) and Urinary Tract Infection

Program officer: Marguerite Evans, MS

Purpose of proposed initiative: To support basic and clinical research on the role of cranberry in the prevention and treatment of urinary tract infection, eventually leading to definitive phase III trials.

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Why Not:

Usually 9-10 — Agreed upon schedule — (Gerry doing)

9-10 / 11 — Commission needs these 2 weeks for Reading the Report

Not all have received every version of report section

(S. G. Return to Staff)

— Looking at Michele's section — Commission agreed on ready access to S+E Com — + has total access to everything is another leap — Commission needs to recommend acceptance or no consensus + then State options —

— Perception of Workgroup efforts are being thrown out will be strong + resistance to changes even greater.

— Staff efforts to meet these agreed upon schedule should be ignored — + they will have Motivation factor to Complete any further revision back on time Because they know you (Chair) may delay even further. ~~Not acceptable to me the Staff Director~~ have to make sure we get the work done in a timely fashion.

— Must adhere to schedule to avoid "stinging criticism" at meeting of not enough time to adequately review the report. I don't want this statement made at the Final Meeting with reporters Present

— Copyediting person is on Board for editing to start on 25th — due date for comments — 16th (14 → 9 days)

— We have 4 of 14 days (≈ 30%) of review time - not good.

changes - we get areas of agreement

new concepts ~~in meeting~~ — we have time for discussion of possible

To Jim Personally

(2) Present your views to all of Commission members ~~like~~ similar to other

(1) Give your View on World View for these Commissioners to Consider

Wellness OK

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EARNINGS AND LEAVE STATEMENT

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ITEMIZED EARNINGS & DEDUCTIONS		SALARY CURRENT	ADJ	YTD	OTHER PAY INFORMATION
EARNINGS	HOURS				CUMULATIVE RETIREMENT
BASE	80.00	5,013.60		129,985.60	FERS: 1890.00
CASH AWARD				2,500.00	
GROSS		5,013.60		132,485.60	YTD TSP
DEDUCTIONS					EMPLOYEE:
					TSP CONTRIB. 10500.00
RETIREMENT (FERS)		40.11		1,078.56	EMPLOYER MATCHING:
MEDICARE		72.70		1,921.11	TSP CONTRIB. 4781.42
OASDI				4,984.80	EMPLOYER BASIC:
FEDERAL TAX (M-03)		958.51		24,124.12	TSP CONTRIB. 1203.36
STATE TAX (MD M-03)		346.75		8,718.42	
LIFE INSURANCE (CODE C0)		20.62		534.56	
BONDS		200.00		5,200.00	
THRIFT SAVINGS PLAN ACCOUNT:					BOND INFORMATION
EMPLOYEE CONTRIBUTION		187.60		10,500.00	
					1 $200 I PURCHASED
TAXABLE INCOME		4,826.00		121,985.60	
NET CHECK TO BANK		3,187.31		75,424.03	

LEAVE	TYPE OF LEAVE	USED THIS PP	PRIOR YR BAL	EARNED YTD	ADVANCED	USED YTD	CURRENT BALANCE	OTHER LEAVE INFO
	ANNUAL		64.00	96.00			160.00	SCD: 06-04-2000
	SICK		64.00	96.00			160.00	LV. CAT: 4
	ADMIN					6.50		MAX. C/O: 240.00
								PAY PERIOD 26
								LEAVE PERIOD 24

	SSN: - -	PPE: 12-15-2001
STEPHEN C GROFT	GRADE/STEP: -0	TIMEKEEPER: 11523
2 HARVARD COURT	PAY PLAN: AD	TERMINAL: 39
ROCKVILLE, MD 20850	BASE SAL: 130800	CAN: 28338443
	HR RATE: 62.67	PERM/TEMP CODE: 1

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OF (Organization)

☐ PLEASE PHONE ▶ *(Enter area code, if necessary)* ☐ DSN

Dean Crush

☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU

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7

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Plaza 1 & 2

301-468-1100

Groft, Stephen (NCCAM)

From: Jean Kazares [jkazares@palladianpartners.com]
Sent: Tuesday, January 15, 2002 1:15 PM
To: Chang, Michele (NCCAM); Groft, Stephen (NCCAM); Kingsbury, Doris (NCCAM)
Subject: WHCCAMP Meeting February

Location:

DoubleTree Hotel Rockville
Plaza I and II
1750 Rockville Pike
Rockville, MD 20852
(301) 468-1100

I need to know the commissioners arrival and departure dates by Monday, Jan. 21st as my rooming list is due to them.

FYI: Don't e-mail anything to Anita as she is out on Maternity leave and will not be returning until March 1 so I am doing everything for the Feb. meeting.

Jean Kazares
Palladian Partners
1010 Wayne Avenue
Suite 1200
Silver Spring, MD 20910
Phone: 301-650-8660
Fax: 301-650-8676
e-mail: jkazares@palladianpartners.com

Quackwatch Home Page

Notes on James S. Gordon, MD, Chair of the White House Commission on Complementary and Alternative Medicine Policy

E. Patrick Curry

James S. Gordon, MD, Chairman of the White House Commission on Complementary and Alternative Medicine Policy, is a clinical professor of Psychiatry and Family Medicine at Georgetown University School of Medicine. He is also associate clinical professor in the Department of Psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. He is a Phi Beta Kappa Harvard graduate (1962) who also graduated magna cum laude from Harvard Medical School (1967) [1].

He is a fellow of the Fetzer Institute, the foundation that funded the 1991 study by David Eisenberg, MD, that exaggerated the usage of alternative medicine by Americans. The Fetzer Institute funds a large array of alternative medicine initiatives and has even sponsored forums for advocates of psychedelic experience and spirituality. Dr. Gordon is best known for running The Center for Mind-Body Medicine in Washington, D.C., which sponsors conferences on aberrant and implausible cancer remedies [2].

Immediately upon his 1967 graduation from medical school, during the 1960s counterculture, Dr. Gordon volunteered for one year at the Haight-Asbury Free Clinic in San Francisco, helping to ease young "seekers" through their experimentation with drugs. He became enamored with the "Insanity is Sanity" philosophy of British psychiatrist R. D. Laing. He studied with Laing in London in the winter of 1969-70 [3] during the period when Laing was deteriorating under the effects of years of his own personal LSD experimentation [4].

Then, during his psychiatric residency at New York City's Albert Einstein College of Medicine, Dr. Gordon attempted to implement Laing's concept of a "therapeutic community". There, according to Dr. Gordon, psychotics could simply "come and go through their psychosis." He came to believe that serious psychological illnesses like schizophrenia "seemed instead like different ways of being." [5] Dr. Gordon then went on to the National Institute of Mental Health (NIMH), having a number of research positions relating to adolescent and community psychiatry. During this time, he also became increasingly involved with aspects of "holistic medicine." By the late 1970s, Gordon was well placed in NIH and was appointed director of a study of alternative mental health services for The President's Commission on Mental Health under the Carter Administration.

"Alternative Services - A Special Study," [6] Dr. Gordon's short appendix in the 1978 commission report, included sections praising holistic medicine and the midwifery philosophy of a counterculture commune, "the Farm," which was founded by psychedelic advocate Stephen Gaskin. An entire section of Gordon's report concerns "Alternative Treatments for Psychotic Adults." It supports the "creative insanity" philosophy of Carl Jung and R. D. Laing as an "alternative treatment for psychotic adults." R. D. Laing is quoted as referring to schizophrenia as "a voyage into self of a potentially revolutionary nature."

While he was directing this presidentially commissioned study, Gordon was a supporter of the movement of the Bhagwan Shree Rajneesh, the authoritarian Indian guru who was deported from the United States in 1986 after being accused of poisoning local townspeople who opposed his commune in Antelope, Oregon [7]. Dr. Gordon was introduced to the ideas of Bhagwan Shree Rajneesh by his

acupuncture teacher. He became a practitioner of the Bhagwan's wild Sufi dancing technique called Dynamic Meditation, which he also offered as a therapy in his psychiatric practice. This consists of a "mind expanding" technique of whirling and spinning to dizziness and sometimes hallucination.

A recent interview with Gordon's acupuncture teacher, Shyam Singha D.O., D.Ac., who introduced him to the Bhagwan, is available online [8]. Singha claims the education of Gordon to be one of his two greatest successes: "His students have included Dr. J.R. Worsley, the renowned English acupuncturist and educator, and Dr. James Gordon, the holistic physician and author from Washington, D.C. who serves on the faculty of the Georgetown University School of Medicine."

By the mid-70s, while a follower/disciple, Dr. Gordon attempted to get an NIMH grant to "study" Rajneesh at his commune in Poona, India. The State Department intervened, quashing the NIMH grant because Rajneesh was considered a cult figure. Undeterred, Gordon traveled to India at his own expense to study with Rajneesh. He was impressed with how the commune combined Western human potential therapies (rebirthing, attack, primal, orgone therapy, etc) with Eastern mysticism in Rajneesh's attempt to construct a "New Man." He was also impressed with the wide variety of "alternative" medicine offered at the commune. His close involvement continued after the wealthy Rajneesh, under investigation from Indian tax authorities, moved his commune to the United States -- eventually taking over the town of Antelope, Oregon. A very sizable percentage of Rajneesh's followers were psychologists, psychiatrists and social workers. A number of the commune's therapeutic group leaders were associated with the San Francisco's Esalen Institute -- a northern California nursery of the New Age movement.

Gordon's 1988 book "The Golden Guru" purports to be a psychological study of Rajneesh's movement as it turned from a world transforming force to an authoritarian controlling group. However, the book is filled with elaborate apologies both for the Rajneesh and for Gordon's own involvement with the cult. In this book, he describes his own "rebirthing" experience at Rajneesh's Indian commune [10], defends the commune's use of violent psychotherapies [11], justifies Rajneesh's accumulation of 93 Rolls Royces as a spiritual lesson showing "contempt" for wealth [12], and partially blames the Oregon commune's deterioration on the intolerance of local Oregonians. Gordon appears to have been an enthusiastic supporter of the Rajneesh from the early 1970s through the time of Rajneesh's expulsion from the United States in 1985 under threat of prosecution for conspiring to poison Oregon townspeople and commune members. (In 1984, more than 700 people had salmonella poisoning after Rajneesh and his followers inoculated area restaurant foods with fecal bacteria in attempt to keep local residents away from the polls.)

Dr. Gordon to this date continues to sell Audio CDs of the Rajneesh's "Dynamic Meditation" and "Kundalini Meditation" at his own Center for Mind-Body Medicine's Online Bookstore. The tapes are sold under the deceased Rajneesh's pseudonym of "OSHO." [13]

During the 1980s Gordon continued to gain influence within alternative mental health and holistic medicine circles. When the Office of Alternative Medicine (OAM) was founded in 1992, he was one of three co-directors of the OAM's Mind-Body Panel, along with Dr. Larry Dossey and Jungian transpersonal psychologist Jeanne Achterberg. Their seminal Mind-Body Intervention report laid the basis for the mystical, parapsychologically-oriented direction of OAM's and NCCAM's Mind-Body research [14].

Dr. Gordon was appointed the very first chairman of the OAM's Program Advisory Council. Through his Center for Mind-Body Medicine, Gordon has also organized a series of Comprehensive Cancer Care Conferences that have gathered together practitioners of aberrant methods with officials of the NIH and the American Cancer Society. Both latter organizations appear to want to cooperate with advocates of

the New Age medicine [15].

Gordon's book based on these conferences, "Comprehensive Cancer Care," is included on the Quackwatch web site's list of non-recommended cancer books [16]. Another of Gordon's books, "Manifesto for a New Medicine," supports almost all aberrant alternative practices..

Dr. Gordon continues to embrace many ideas outside of medicine, sitting on the Scientific Advisory Board of Harvard psychiatrist Dr..John Mack's Program for Extraordinary Experience Research (PEER). Dr. Mack believes that hundreds of thousands of Americans may have at one time been abducted by aliens and uses "alien-abduction therapy," which assumes the experiences are real [17].

Dr. Gordon was a speaker at a 1997 conference of followers of "orgone energy" theorist Wilhelm Reich [18]. Gordon challenged the participants to undertake clinical trials of Reich's "orgone accumulator." [19] Speakers at this conference also led discussions of UFOs. Dr. Gordon also has a special interest in UFOs, having written a 1991 article on "The UFO Experience' for the Atlantic Monthly.

Dr. Gordon apparently supports Jungian "transpersonal" mystics, as at the Life After Death conference in 1999 [20].

Dr. Gordon interjected himself into the Oklahoma Bombing case. He sent a statement to the court in the trial of Terry Nichols, claiming that based on his reading of Nichol's letters that Nichols was not violent and should not receive a long prison term [21].

Dr. Gordon's views of the importance of his activities with the White House commission can be gleaned from the following description and quotations from one of his talks. Though not explicit here, the changes he predicts would revolutionize medicine along the lines expressed in his *Manifesto for a New Medicine*, and also revolutionize all of biology. Dr. Gordon was quite enthusiastic when he discussed the importance of the commission; he believes that the commission will have nothing less than a revolutionary effect on the future of medicine:

> I believe that the report we are going to provide the president in two years has the potential to be, for medicine in the 21st century, as important as the Flexner report was to medicine in the 20th century. The Flexner report was the result of a committee created at the beginning of the 20th century to develop policies and standards for medical education. The report of the Flexner commission had a profound effect in establishing standards for scientific medical education that helped bring American medicine into modern times. I believe our commission can have an equally significant effect in this century. I don't perceive our goal as limited to discussing research approaches to CAM practices; I see it far more expansive. I believe this commission has an opportunity to look at medicine and health care from a different perspective that can lead to a new model of medicine and even a new model of human biology [22].

WHCCAMP is expected to recommend to President Bush that nonsensical medicine be afforded equal status with standard scientific medicine. Its November 2001 draft report recommends across-the-board "integration" of CAM into government health agencies and the nation's medical, medical education, and insurance systems. This effort would be overseen by a coordinating office "at the highest possible level," which would coordinate with a national policy advisory board established by the Secretary of the Department of Health and Human Services. These recommendations are an affront to medical science and an assault on consumer protection.

For Additional Information

- White House Commission Stacked against Science
- Scientists Urge Surgeon General to Disband WHCCAMP

Footnotes

1. James S. Gordon, *Curriculum Vitae*, March 13, 1999.
2. The Mind Body Center
3. Interview with Barry Chowka. *Nutrition Science News*, September. 1996 ; documentary copy November 19,2001.
4. Burston, Daniel, *The Wing of Madness: The Life and Work of R. D. Laing*, Cambridge, Mass; Harvard University Press; 1996: 79-92, 51-61, 125-131.
5. Interview with Barry Chowka, *Nutrition Science News*, September 1996.
6. *Alternative Services: A Special Study (Final Report to The President's Commission on Mental Health of the Special Study on Alternative Mental Health Services, James S. Gordon, Director))*, in Task Panel Reports Submitted to the President's Commission on Mental Health, President's Commission on Mental Health, Volume II, Appendix. 1978.
7. Gordon, James S., *The Golden Guru*, Lexington, Mass; The Stephen Greene Press; 1987.
8. Shyam Singha Interview; documentary copy November 18, 2001.
9. Gordon, *The Golden Guru,* pp. 17-18.
10. Ibid., pp. 86-89.
11. Ibid., pp. 84-86.
12. Ibid., pp. 114.
13. Online Bookstore of Center for Mind-Body Medicine; documentary copy November 18, 2001.
14. Mind-Body Interventions, Report of Office of Alternative Medicine Mind-Body Panel, documentary copy October 4, 2001.
15. Center for Mind-Body Medicine
16. A special message to patients seeking alternative cancer treatments. Quackwatch Web site.
17. PEER website; documentary copy November 19, 2001.
18. Wilhelm Reich Centennial: An Energetic Celebration, Nov. 1997; documentary copy, September 9, 2000.
19. Mannion, Michael, "The Orgone Energy Accumulator: It is Time for Clinical Trials"; documentary copy November 19,2001. Note: Gordon collaborator, Wilhelm Reich Conference organizer, Neutraceutical Journalist and UFO reporter Michael Mannion reports in "Energy Medicine and Encounters with Non-Human Intelligences" that "energy medicine" may have been introduced to Earth by encounters of "subtle energy healers" with space aliens; documentary copy November 19,2001.
20. 1999 "LifeDeathAfterDeath" conference of parapsychologists and mystics; documentary copy November 19, 2001.
21. Defense expert: Nichols had no outrage over Waco; Denver Post Online, June 3, 1998, Also, "Judge to Sentence Nichols for Oklahoma bombing", CNN June 4, 1998.
22. Gonzalez, Nicholas, M.D. "Alternative Medicine Comes of Age" posted at Dr. Gonzalez' website; documentary copy November 19,2001. Note: Dr. Gonzalez is the recipient of a major NCCAM research grant to study enema and vitamin treatments for cancer. He is a strong supporter of Dr. Gordon. He has also been convicted in two civil suits of medical malfeasance in his treatments of cancer patients according to a 4/20/00 Associated Press article by Samuel Maul, "Coffee Enema Doctor Sentenced."

This article is slightly modified from the Fall 2001 issue of The Scientific Review of Alternative Medicine. Mr. Curry is a consumer health activist who resides in Pittsburgh, Pennsylvania.

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This page was revised on February 20, 2002.

Teacher to Teacher

BY NORA ISAACS

A Call to Action

Your input to a White House Commission on complementary medicine could affect the future of regulation for yoga teachers.

Will the federal government be looking in on your yoga class in the future?

THE FIRST MEETING of the White House Commission on Complementary and Alternative Medicine (CAM) in July 2000 began with Chairman Jim Gordon asking everyone in the room to inhale and take a moment of silence. The Commission—which included M.D.s, Chinese Medicine specialists, acupuncturists, directors of several complementary medicine centers, and representatives from groups like the National Black Women's Health Project and the Poarch Band of Creek Indians—took a collective inhale. "The purpose of taking a deep breath is to remind ourselves to relax," continued Gordon. "We have a lot of work to do together, but that work needs to be done in a spirit of openness and of collaboration and calm, as well as with enthusiasm."

With that breath began the government's entry into the world of yoga. Strange bedfellows? Perhaps, but there is no turning back. The Commission was formed by an executive order from President Bill Clinton and is charged with gathering some kind of coherent information on the extraordinary array of complementary and alternative therapies in the United States. Next March, the Commission will submit a report to President George W. Bush and Congress offering recommendations on how to determine public policies for CAM therapies, including the licensing, education, and training of CAM healthcare practitioners.

It's that last part that has some yoga teachers nervous. "Just the very fact that this Commission will be reporting to a George Bush administration totally terrifies me," says Michael Cooper, a San Francisco–based yoga instructor who has been teaching for 12 years. "When anyone else tries to define my relationship with my inner teacher—the essence of yoga—I feel very uncomfortable."

The Definition of Yoga

SINCE ITS INCEPTION, the Commission has been on a major fact-finding mission. "It's not up to us to *decide* these issues," stresses Gordon, a psychiatrist who has been working with complementary and alternative therapies since 1965 and is the founder and director of the Center for Mind-Body Medicine in Washington, D.C. "It's up to us to raise the questions and report on what people are telling us." So far, the Commission has listened to insurance companies, citizens' groups, major medical schools, professional associations, and

consumers to get input. To date, 3,000 people and organizations (including the FDA, NIH, and AMA) have testified at town hall meetings or on paper.

Although its purpose is not regulation, many people in the yoga community fear that could be the final result of the Commission's work. The very definition of a "CAM therapy" is at the heart of the debate. Because the Commission's recommendations on practices like chiropractic, acupuncture, massage, reflexology, and yoga will ultimately decide what a CAM therapy is, the first question is figuring out whether yoga should even be included on the list. "I don't know if we've gotten a clear sense about what the people who teach yoga want," says Gordon. It doesn't take long to find out why. Just put an Iyengar teacher in a room with an Integral teacher and ask them about the importance of the physical body in yoga, or ask a Bikram and an Ashtanga teacher the "right" way to teach Trikonasana. It's hard to define yoga for an outside entity when we in the yoga community have difficulty defining it for ourselves.

As part of its information-gathering process, in February 2001 the Commission sent a letter to the Yoga Alliance, the closest thing we have to a regulatory body. The letter asked nine questions: about national educational standards for yoga undergraduate, postgraduate, and continuing education; whether these national standards included exposure to conventional or Western or other complementary therapies; whether there should be national standards and how to define them; and how any such standards should be implemented. "The questions didn't reflect where yoga teachers see themselves," says Yoga Alliance President Rama Berch. "They were the kinds of questions a doctor would ask a yoga teacher before they sent out a referral." The Yoga Alliance answered the first few questions as best it could, but the rest were questions it hasn't even started asking itself.

The fact that the Yoga Alliance answered for the yoga community, however, troubles some teachers who feel the organization doesn't represent them or their needs. "This thing that says I'm only a competent teacher if I've had a thousand hours through a particular organization leaves out the fact that learning to be a teacher is a lifetime project," says Cooper, whose first training was at White Lotus Foundation, which he points out, makes him unable to bear the Yoga Alliance credential Registered Yoga Teacher (RYT). "It's not like you go to a certain program and you become a 'real teacher,'" he adds.

Is Yoga CAM or Isn't It?

BASED ON THE Commission's recommendations, the government could decide that yoga is a CAM therapy. If yoga teachers are included on the list of CAM providers, the floodgates could open for huge numbers of people from all socioeconomic levels to start taking yoga, especially people who stayed away because it wasn't medically approved or covered by insurance.

"This could provide maximum employment for yoga teachers, as well as

legitimization and inclusion in the major medical paradigm," says Berch. While increasing the need for qualified yoga teachers is a good thing, any regulations requiring a certain number of training hours that might be put into place by the government could put some experienced, wonderful teachers out of business.

The possibility of listing yoga as a CAM therapy instantly brings up discussion of insurance coverage. "One of the odd things about CAM is that it often degenerates into a talk about insurance, and the moment that happens, something shifts," says Steve Olson, president of the American Massage Therapy Association (AMTA). "If we just talk about health care without talking about insurance coverage, it might be a cleaner topic."

Unfortunately, the complex issues of reimbursement won't go away. If insurance companies start paying for yoga classes, it could mean that teachers won't be able to attract students unless they are "preferred providers" or otherwise acceptable to insurers. It could also translate into headaches for teachers: delayed payment, increased paperwork, storing files, and a host of other practical problems such as doctors telling yoga teachers how to work with their patients. Yoga teachers will have to learn to work with medical doctors and negotiate some difficult situations: How to answer a question from a doctor who has never taken a yoga class? What if these doctors don't know about the different styles of yoga? And doctors will be asking some tough questions: Are yoga teachers medically qualified to handle someone with emphysema? And what is the scientific documentation for that?

"When physicians see how well the patients are doing using yoga, they get excited," says Fair.

William Fair, commissioner and former cancer surgeon at Memorial Sloan-Kettering Cancer Center, believes that answers will come as the word spreads about the benefits of yoga. Fair, one of the founders of Haelth, a complementary medicine center in Manhattan that incorporates several forms of healing such as yoga and acupuncture to complement clients' medical treatment, says that in the first five months of business, 10 percent of Haelth's referrals came from physicians. "When physicians see how well the patients are doing [using yoga], they get excited," he says. "The more physicians learn to appreciate there is healing in yoga, the more that is going to be accepted." As a cancer survivor who integrated yoga, herbs, meditation, and exercise into his personal healing regimen after his cancer recurred, Fair hopes to run clinical trials on patients undergoing chemotherapy or radiation in the future.

In a second scenario, the Commission could recommend that yoga should *not* be included on the list of CAM therapies. If that happens, some folks would say that we had just missed the opportunity for legitimacy in the medical community.

Others might sigh in relief at the prospect of being left alone, but there are also some unappealing repercussions to this possibility. "If yoga is off the list and they write legislation from that list, yoga is not merely ignored, it could be registered and legislated against—the standards raised so high that people could get put out of business or put in jail. It could be a serious problem," says Berch. Looking at what happened with midwifery and naturopathy, which are illegal in some states, presents another perspective of the possible outcomes. On the brighter side, yoga's being left off the list could be to our advantage if other CAM therapies wind up governed by federal legislation.

"Who knows what the President and Congress are going to do with the recommendations?" asks Berch. "Which direction this goes, we don't know. Does yoga get included in the list? The repercussions of this question are very big."

> "It will take up to two to five years to come up with standards for yoga therapists."

A Middle Ground

THE FINAL RESULT may not be cut and dried. CAM proponents have pointed to a dichotomy in how yoga is taught today, what Fair calls "hard body versus healing yoga." Perhaps the yoga instructors who teach classes for relaxation or as a spiritual discipline will be left unregulated, while those teaching yoga therapy for people with conditions like Multiple Sclerosis or emphysema will be included in the CAM model and ultimately certified. "Some yoga teachers don't want to bother with people who are sick," says Fair. "But this could alter the course for people who want to do healing yoga, and hopefully that would be done where the role of yoga fits in as a component." Which brings up another set of questions regarding advanced training and specialization. "It will take two to five years to come up with standards of what a yoga therapist should

know," says Berch, who says her organization didn't plan on delving into these difficult questions so soon.

One thing does seem clear: More research needs to be done if yoga is to be included effectively in a medical model. "There is a really strong understanding that conventional health professionals need to know more about CAM approaches, and CAM professionals need to know more about conventional approaches," says Gordon.

What Gordon finds most valuable, and what has sparked the most interest among the Commission, are approaches that include yoga in a total program, like the work of Commissioner members Dean Ornish, M.D. on reversing heart disease, and Jon Kabat-Zinn, M.D. with stress reduction. "The power of these therapies comes from an integration into a broader approach," he says. According to Gordon, more studies on integrative programs such as these could set the stage for possible government funding in the future. "We have heard from a number of major insurance carriers that people are looking for cost-benefit studies: Does this work, and what does it cost? We are looking at the evidence and making the recommendations about the kinds of demonstrations that should be made."

Anybody's Guess

WILL WE HAVE government-regulated teacher trainings, or will things stay just as they are? Perhaps CAM therapies will end up looking like the medical profession, which is regulated on a state-by-state basis. Or perhaps each profession will put into place an internal system for credentialing and quality control. In which case the question becomes, what will be yoga's governing body?

One of the things the Commission is looking at is the ability for the various CAM therapies to self-regulate. According to Berch, less legislation is likely if rules are already put into place. "If we are completely disorganized and have no self-governing body, the Commission will feel the responsibility to regulate," she says. Since Yoga Alliance can only speak out for

continued on page 160

continued from page 135

the number of teachers it represents, she encourages teachers to join. "I'd love to see teachers unregulated because I know what regulation looks like," says Berch. "But if we are going to be regulated, then we should get to write the rules."

In August, the Commission submitted an interim report to give a sense of what it has learned so far. "The whole issue of licensure and certification is one that we don't have recommendations for yet," explains Gordon. "But it is clear that certification is a perfectly legitimate way for professions to develop and mature."

As Gordon told his commissioners during that very first meeting almost two years ago, they have a lot of work to do. And things are likely to get only more complicated as yoga's popularity continues to grow, the Bush administration settles into office, and more diverse voices are heard. "They are in a terribly difficult position," says AMTA's Steve Olson. "A national commission is trying to make comments on therapeutic approaches that are regulated at a state or local level or those which are completely unregulated." But where there is chaos, there is opportunity. The input of yoga teachers can affect CAM's recommendations to the White House, and the Commission encourages everyone who has a concern, from practitioners to the general public, to express their views to the Commission before the March 2002 deadline.

Ultimately, it is the teachers and students whose lives may be affected by the decision-makers on Capitol Hill. "Yoga is a balance," says Cooper. "There need to be standards and accountability, but who decides? What is yoga? To me, it's a mystery. It's like mysticism. You can't really legislate an inner experience." ■

Managing Editor Nora Isaacs urges you to send CAM a note with your thoughts on the matter.

RESOURCES: *Contact CAM by calling (301) 435-7592, e-mail* whccamp@mail.nih.gov, or log on to www.whccamp.hhs.gov; *contact Yoga Alliance,* www.yogaalliance.org, *(877) yogaall; or contact your local representatives.*

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TO: White House Commission on Complementary and Alternative Medicine Policy

FROM: Dean Ornish, M.D.

Thank you so much for the draft of our final report. I appreciate the opportunity to serve on this Commission with each of you. I respect the wisdom and diversity of perspectives that each person brings.

I am sorry that our meeting was scheduled at a time when I am unable to attend both days, although I will be there on Friday and look forward to seeing each of you at that time.

Rather than giving a line-by-line critique, which I am willing to do, I think there are larger issues that first need to be discussed. During our meetings, I have often found myself in the unusual role, for me, of being the more conservative voice of restraint and moderation in our recommendations. I addressed these concerns to some degree in my memo of 12/23/01, but not much has changed in the report since then. My perspective is sufficiently different from what is reflected in the current draft of our final report that I am not comfortable signing it in its current form.

As you know, my colleagues and I at the non-profit Preventive Medicine Research Institute have spent the past 25 years conducting a series of research and demonstration projects assessing both the medical effectiveness and cost effectiveness of various CAM modalities. We understand how powerful some CAM interventions can be in health and healing, for example, even in reversing the progression of severe coronary heart disease.

The reason that we have spent so much time and energy conducting research is that we believe in the value of science in helping to sort out what is true from what is not, to help sort out what works from what doesn't, for whom, and under what circumstances. We understand the limitations of science but also its power. We know how difficult the obstacles can be in conducting good science.

Nevertheless, I am increasingly uncomfortable with the far-reaching recommendations and advocacy of complementary and alternative medicine contained throughout our report, because most CAM interventions have not yet been proven to be either medically effective or cost effective. I imagine that many of these eventually may be proven to be beneficial, but for most CAM modalities, that scientific evidence is not yet available.

I understand that there are many modalities of allopathic medicine that are widely used and often reimbursed that have not been proven to be either medically effective or cost effective, and many have side-effects that are more harmful than many CAM modalities. However, I believe that our response should be to hold all systems of health and healing, including allopathic and CAM, to the same rigorous standards of good science and health services research-not, as we often do in our report, to advocate the wide implementation and reimbursement of CAM modalities that are yet unproven. "Two wrongs don't make a right." I think it is premature to recommend how to implement CAM in virtually every sector of our society. We are much earlier on the curve.

I would like to see more emphasis in our recommendations on the importance of conducting scientific research and demonstration programs assessing the safety and efficacy of both CAM and non-CAM approaches. We should only recommend that CAM and non-CAM approaches be licensed, implemented, and reimbursed when they first have been found to be safe and effective.

As you know, conducting good scientific studies is difficult and expensive. There are many obstacles. I understand the limitations of conventional experimental design as well as the power of randomized controlled trials. I am all for innovative approaches to conducting good science, but I am not in favor of making recommendations to widely implement, license, train, and pay for CAM modalities that are yet unproven.

I am very sympathetic to the desire to increase the implementation, education, and reimbursement of various CAM modalities. I am well aware of the inequities and hypocrisies in the current system. For example, I have personally experienced on more than one occasion that there is often a double standard in trying to get CAM research published. CAM research is often held to a higher standard. I also understand how difficult it can be to get reimbursement from third-party payers and Medicare for CAM modalities, as I have spent most of my career fighting these battles and continue to do so. It can be very frustrating and discouraging at times. I understand that there are powerful economic interests against CAM.

Even so, I think the most appropriate recommendation would be to remove these inequities, strongly recommend that more research and demonstration projects be conducted, and dramatically increase funding for rigorous research into the possible benefits and liabilities of a variety of CAM modalities (especially those that are in widespread use). I remain concerned that we are making too many recommendations about the importance of including CAM in a variety of corporate, governmental, and social arenas and not enough about the wisdom of moving ahead in a more judicious and measured way.

In our recommendations, we tend to lump all CAM modalities together, from the proven to the unproven, from the more well-accepted to the outrageous. CAM is an umbrella that includes almost everything. For example, action recommendation 1.5 in the chapter on "Education and Training" states, "The eligibility of CAM students for existing loan programs should be expanded." Which CAM students? And why should tax dollars be spent to train people in CAM approaches that have not yet been proven to be safe or effective? This is only one of many examples.

Many, if not most of our recommendations are not about specific modalities, they are about "CAM." We heard testimony from some people who argued that all CAM modalities should be widely implemented and not regulated because they are inherently safe and effective. While most of us probably would not agree with this statement, many of our recommendations appear as though we presume that this statement is true.

In Table 1 of the History of CAM chapter, a variety of CAM modalities are listed, including Ayurvedic medicine, naturopathic medicine, homeopathic medicine, and so on. Walk into any health food store, and what passes for CAM is almost anything. We often don't distinguish among these in our recommendations.

There is a pervasive, general ethos that goes throughout the document that assumes that many, if not most, of CAM modalities have been proven. There is a presumption of safety and efficacy for most CAM modalities throughout our report. There is an implicit and sometimes explicit assumption in many of these recommendations in our report that they work. Even though we sometimes qualify our recommendations to those that are safe and effective, so few have been proven to be safe and effective, why are we making hundreds of recommendations when, as Linnea wrote, "There is no there-there." Most of these modalities have not yet been proven to be safe or effective by any standard, much less randomized controlled trials.

Given this lack of evidence, I believe that it is premature to be making so many sweeping recommendations about CAM in reimbursement, in the workplace, in education, National Health Service Corps, etc. For example, it's premature to set up fellowship programs to train people in modalities that haven't yet been proven to work. To me, the tone of the document should be much more modest and self-effacing.

I'm not saying that CAM modalities aren't valuable, safe, or effective; I'm saying we don't have evidence yet for most of these. Until we do, we should be more circumspect in making sweeping recommendations.

The question is not "Should people be using CAM," as they are already. Because of the compelling need to find out what works, I believe that we should recommend to dramatically increase the amount of funding going for CAM research. We recognize that not everything that counts can be counted, not everything meaningful is measurable, and we may need to come up with innovative paradigms for studying some CAM modalities and systems, but we first need to put most of our efforts and resources into gaining a better understanding of whether or not these work, to what degree, for whom, and under what circumstances and what conditions. *Then* we can come back and reassess the evidence, discuss the health policy implications and how best to implement those that truly are safe and effective.

Our report will have much more credibility if we acknowledge how much we don't know instead of recommending how we can widely implement what we don't know. In the final analysis, I think our report will do more to advance CAM if we take a more reasoned and balanced approach than if we are viewed as advocates.

I understand that our final report is due before March 7th. However, I suggest that we need to continue our dialogue until we reach consensus. I think it may be better to delay our report until we can reach consensus than to submit a report with dissenting opinions or with several members' names removed. I doubt that we can accomplish this in only two days. United we stand.

I look forward to seeing you on Friday.

Dean