Actions

12.1 The Secretary of Health and Human Services should form a public-private partnership to review new and existing websites and to develop voluntary standards promoting accuracy, fairness, comprehensiveness, and timeliness of information on CAM web sites, as well as the disclosure of sources of support and possible conflicts of interest. Sites reviewed and found in compliance with the standards could publicize the fact and display a logo denoting their merit.

12.2 Funding should be provided to the Department of Health and Human Services and the Department of Education to conduct a joint public education campaign that teaches consumers how to evaluate health care information, including CAM information, on the Internet and elsewhere.

12.3 Congress should protect consumers' privacy by requiring all health information sites, including CAM sites, to disclose whether they track users and if so, how that information is used and stored, including whether it is sold to third parties.

Recommendation 13: Information on the training and education of providers of CAM services should be made easily available to the public.

Actions

13.1 The Commission recommends that states require all persons providing CAM services to disclose information regarding their level and scope of training and to make it easily available to consumers.

13.2 The Commission recommends that states disclose information on State guidelines, requirements, licensure, certification, and disciplinary actions of health providers, including CAM providers, and make it easily accessible to the public.

Recommendation 14: CAM products that are available to U.S. consumers should be safe and meet appropriate standards of quality and consistency.

Actions

14.1 The efforts of both the public and private sectors to ensure the development, validation, and dissemination of analytical methods and reference materials for dietary supplements should be accelerated.

14.2 The proposed Good Manufacturing Practices for Dietary Supplements should be published expeditiously, followed by a timely review of comments and completion of a final rule. The Food and Drug

Administration should be provided with adequate resources to complete this task.

14.3 Adequate funding should be provided to appropriate Federal agencies, including U.S. Customs and Food and Drug Administration inspection authorities, to enforce current laws monitoring the quality of imported raw materials and finished products intended for use as dietary supplements.

14.4 Manufacturers should have on file and make available to the FDA upon request scientific information to substantiate their determinations of safety, and current statutory provisions should be periodically reexamined to determine whether safety requirements for dietary supplements are adequate.

14.5 An objective process for evaluating the safety of dietary supplement products should be developed by an independent expert panel.

Recommendation 15: Provisions of the Federal Food, Drug, and Cosmetic Act, as modified by the Dietary Supplement Health and Education Act of 1994, should be fully implemented, funded, enforced, and evaluated.

Actions

15.1 The Food and Drug Administration and other agencies with regulatory responsibilities should be provided with additional resources to 1) enforce the Dietary Supplement Health and Education Act's regulations regarding labeling of dietary supplements, 2) enforce current provisions requiring that dietary supplements be labeled in English, even if the same information is also included in another language, and 3) employ additional professionals with expertise in dietary supplements.

15.2 Current provisions requiring disclosure of material facts by manufacturers of CAM products should be enforced, and manufacturers should meet their responsibility to disclose material facts on the label, package, and/or package insert, so that the public will have information about known risks and well-documented significant interactions. Information on potential benefits of dietary supplements should also be made easily available at the time of purchase.

15.3 Congress should periodically evaluate the effectiveness, limitations, and enforcement of the Dietary Supplement Health and Education Act of 1994, including its impact on public health, and take appropriate action to ensure the public's safety.

Recommendation 16: Activities to ensure that advertising of dietary supplements and other CAM practices and products is truthful and not misleading should be increased.

Actions

16.1 Congress should provide additional support to the Federal Trade Commission to 1) expand efforts to identify false and deceptive advertising of CAM-related health services and products and take appropriate enforcement action when necessary, 2) use appropriate CAM experts in the process of examination of CAM-related advertising, 3) increase activities to help consumers distinguish useful and reliable information from deceptive and unsubstantiated advertising in all forms of marketing and advertising, including at the point of purchase; and 4) seek additional public comment on the benefits and potential problems in the advertising of CAM-related services and products.

Recommendation 17: The collection and dissemination of information about adverse events stemming from the use of dietary supplements should be improved.

Actions

17.1 Congress should require dietary supplement manufacturers and suppliers to register with the Food and Drug Administration, and the agency should encourage voluntary registration until such a requirement is in effect, so that manufacturers, suppliers, and consumers can be promptly notified if a serious adverse event is identified.

17.2 Recent congressional support for improving the Food and Drug Administration's adverse events reporting system should be enhanced by requiring dietary supplement manufacturers and suppliers to maintain records and report serious adverse events to the agency.

17.3 Additional resources and support should be provided to 1) the Food and Drug Administration to simplify the adverse events reporting system for dietary supplements, and to streamline the database for timely review and follow-up on received reports; and 2) the Food and Drug Administration, the Centers for Disease Control and Prevention, and other appropriate Federal agencies to increase outreach activities to consumers, health professionals (including poison control centers, emergency room physicians, CAM practitioners, and mid-level marketers) in order to

improve both manufacturers' and the public's awareness of and participation in voluntary event reporting.

Access and Delivery

Recommendation 18: The Department of Health and Human Services should evaluate current barriers to consumer access to safe and effective CAM practices and to qualified practitioners and should develop strategies for removing those barriers in order to increase access and to ensure accountability.

Actions

18.1 The Department of Health and Human Services should assist the States in evaluating the impact of legislation enacted by various States on access to CAM practices and on public safety.

18.2 The Department of Health and Human Services and other appropriate Federal agencies should use health care workforce data, data from national surveys on use of CAM, regional public health reports on CAM activities and other studies to identify current and future health care needs and the relevance of safe and effective CAM services for helping address these needs.

Recommendation 19: The Federal Government should offer assistance to states and professional organizations in 1) developing and evaluating guidelines for practitioner accountability and competence in CAM delivery, including regulation of practice, and 2) periodic review and assessment of the effects of regulations on consumer protection.

Actions

19.1 The Secretary of Health and Human Services should create a policy advisory committee, including CAM and conventional practitioners and representatives of the public, to address issues related to providing access to qualified CAM practitioners, provide guidance to the states concerning regulation possibilities, and provide a forum for dialogue on other issues related to maximizing access.

19.2 The Secretary of Health and Human Services, in collaboration with states, should assist CAM organizations that wish to develop consensus within their field of practice regarding standards of practice, including education and training. The conclusions reached by CAM professional groups concerning these matters should be considered by states and regulatory

bodies in determining the appropriate status of these practitioners for such regulatory options as registration, licensure or exemption.

Recommendation 20: States should evaluate and review their regulation of CAM practitioners and ensure their accountability to the public. States should, as appropriate, implement provisions for licensure, registration, and exemption consistent with the practitioners' education, training, and scope of practice.

Action

20.1 The Department of Health and Human Services' policy advisory committee, in partnership with state legislatures, regulatory boards, and CAM practitioners, should develop model guidelines or other guidance for the regulation and oversight of licensed and registered practitioners who use CAM services and products. This guidance should balance concerns regarding protection of the public from the inappropriate practice of health care, provide opportunities for appropriately trained and qualified health practitioners to offer the full range of services in which they are trained and competent, maintain competition in the provision of CAM and other health services, preserve CAM styles and traditions that have been valued by both practitioners and consumers, and determine the extent of the public's choice among health care modalities.

Recommendation 21: Nationally recognized accrediting bodies should evaluate how health care organizations under their oversight are using CAM practices and should develop strategies for the safe and appropriate use of qualified CAM practitioners and safe and effective products in these organizations.

Actions

21.1 National accrediting bodies, in partnership with other public and private organizations, should evaluate present uses of CAM practitioners in health care delivery settings and develop strategies for their appropriate use in ways that will benefit the public.

21.2 Nationally recognized accrediting bodies of health care organizations and facilities should consider increasing on-going access to CAM expertise to ensure that processes to develop accreditation standards and interpretations reflect emerging developments in the health care field.

21.3 Nationally recognized accrediting bodies, using CAM experts, should review and evaluate current standards and guidelines to ensure the safe use of CAM practices and products in health care delivery organizations.

Recommendation 22: The Federal government should facilitate and support the evaluation and implementation of safe and effective CAM practices to help meet the health care needs of special and vulnerable populations.

Actions

22.1 The Department of Health and Human Services and other Federal Departments should identify models of health care delivery that include safe and effective CAM practices, evaluate them, and then support those models which are successful for use with special and vulnerable populations, including the chronically and terminally ill.

22.2 The Department of Health and Human Services should sponsor the development and evaluation of demonstration projects that integrate the use of safe and effective CAM services as part of the health care programs in hospices and community health centers.

22.3 The Department of Health and Human Services should identify ways to support the practice of indigenous healing in the United States and to improve communication among indigenous healers, conventional health care professionals, and CAM practitioners.

COVERAGE AND REIMBURSEMENT

Recommendation 23: Evidence should be developed and disseminated regarding the safety, benefits, and cost-effectiveness of CAM interventions, as well as the optimum models for complementary and integrated care.

Actions

23.1 The Secretary of Health and Human Services should convene a joint public and private task force to identify and set priorities for studying health services issues related to CAM and to help purchasers and health plans make prudent decisions regarding coverage of and access to CAM.

23.2 Federal agencies, States, and private organizations should increase funding for health services research, demonstrations, and evaluations related to CAM, including outcomes of CAM interventions, coverage and access, effective sequencing and integration with conventional therapies, effective models for service delivery, and the use of CAM in underserved, vulnerable, and special populations.

23.3 Federal, State, and private entities should fund health services research on the costs, cost-benefits, and cost-effectiveness of CAM interventions and wellness programs.

23.4 The Secretary of Health and Human Services and the National Committee for Vital and Health Statistics should authorize a national coding system that supports standardized data for CAM. This system should make possible the collection of data for clinical and health services research on CAM, and support compliance with the electronic claims requirements of the Health Insurance Portability and Accountability Act.

23.5 The National Center for Complementary and Alternative Medicine, through its clearinghouse, should provide information on health services research, demonstrations, and evaluations of CAM services and products.

23.6 Public agencies and private organizations should support the development of informational programs on CAM targeted to health plan purchasers and sponsors, health insurers, managed care organizations, consumer groups, and others involved in the provision of health care services.

23.7 Congress should request periodic reports from appropriate Federal departments on coverage of and reimbursement for CAM practices and products for Federal beneficiaries, Medicaid beneficiaries, Federal employees, military personnel, veterans, and eligible family members and retirees, as well as any legislative, regulatory, or programmatic impediments to covering safe and effective CAM interventions.

Recommendation 24: Insurers and managed care organizations should offer purchasers the option of health benefit plans that incorporate coverage of safe and effective CAM interventions provided by qualified practitioners.

Actions

24.1 Health insurance and managed care companies should modify their benefit design and coverage processes in order to offer purchasers, for their consideration, health benefit plans that include safe and effective CAM interventions.

24.2 Health insurance and managed care companies should make use of CAM expertise in the development of benefit plans that include safe and effective CAM interventions.

24.3 Health insurers, managed care organizations, CAM professional associations, CAM experts, private organizations that develop medical criteria, and Federal agencies are encouraged to develop appropriate clinical criteria and guidelines for the use of CAM services and products.

Recommendation 25: Purchasers, including Federal agencies and employers, should evaluate the possibility of covering benefits or adding health benefit plans that incorporate safe and effective CAM interventions.

Actions

25.1 Employers, Federal agencies, other purchasers and sponsors should enhance the processes they use to develop health benefits and give consideration to safe and effective CAM interventions.

25.2 Public purchasers such as the Centers for Medicare and Medicaid Services and the Department of Defense, employers, other health benefit sponsors, and health industry organizations should include CAM practitioners and experts on advisory bodies and workgroups considering CAM benefits and other health benefit issues.

25.3 The Secretary of Health and Human Services, preferably through the Federal CAM coordinating office when established, should maintain a list of opportunities for CAM experts to participate on advisory committees and other workgroups.

25.4 The Secretary of Health and Human Services should direct agencies under his authority to convene workgroups and conferences to assess the state-of-the-science of CAM services and products and to develop consensus and other guidance on their use.

25.5 State governments should consider, as part of evaluating and reviewing their regulations, how regulation of CAM practitioners could affect third-party coverage of safe and effective CAM interventions. CAM in Wellness and Health Promotion

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Recommendation 26: The Department of Health and Human Services and other Federal agencies and public and private organizations should evaluate CAM practices and products that have been shown to be safe and effective to determine their potential to promote wellness and help achieve the nation's health promotion and disease prevention goals. Demonstration programs should be funded for those determined to have benefit.

Actions

26.1 The Healthy People Consortium should evaluate the role of safe and effective CAM practices and products in addressing the10 leading health indicators and develop strategies, including demonstration programs, to encourage the use of CAM practices and products found to be beneficial in addressing these indicators.

26.2 Questions on the extent and use of CAM products and practices should be included in national surveys and other assessment tools including the National Health Interview Survey, the National Health and Nutrition Examination Survey, and the Medical Expenditure Panel Survey. Where appropriate, information from these sources should be incorporated into the Healthy People 2020 goals and objectives.

26.3 The Department of Health and Human Services, as part of the Healthy People 2010 initiative, should support the development of a national campaign to teach and encourage behaviors that focus on improving nutrition, promoting exercise, and teaching stress management for all Americans, especially children. This campaign should include safe and effective CAM practices and products where appropriate.

26.4 The Federal government, in partnership with public and private organizations, should evaluate safe and effective CAM practices and products to determine their applicability to improving nutrition, promoting exercise, and teaching stress management to children. Demonstration programs should be funded for those found to be applicable to children.

26.5 The Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Department of Agriculture, the Department of Education, and other Federal agencies that develop school health guidelines should evaluate the potential applicability of safe and effective CAM practices and products to these school health guidelines. Those found to have benefits should be included in the guidelines.

26.6 Federal agencies, in partnership with the business community, should develop incentives for schools to make lunches and snacks healthful, and to limit the sale-and eliminate the advertising-of high-fat snacks, soft drinks, and other products that do not contribute to healthy lifestyles

26.7 The Department of Health and Human Services and the Department of Labor should evaluate safe and effective CAM practices and products to determine their potential role in workplace wellness and prevention activities, and include them in Federal workplace wellness and health promotion programs and Federal health coverage plans when appropriate.

26.8 Federal agencies, in conjunction with the business community, should develop incentives for employers to include CAM practices and products found to be beneficial in wellness and prevention activities in their workplace wellness programs and health coverage.

Recommendation 27: Federal, State, public, and private health care delivery systems and programs should evaluate CAM practices and products to determine their applicability to programs and services that help promote wellness and health. Demonstration programs should be funded for those determined to be beneficial.

Actions

27.1 The Secretaries of Health and Human Services, Agriculture, Veterans Affairs, and Defense and the Commissioner of the Administration for Children and Families, should evaluate safe and effective CAM practices and products that contribute to wellness and health and determine their applicability to Federal health systems and programs.

27.2 The Secretary of Health and Human Services should facilitate the bringing together of public and private health care organizations to evaluate safe and effective CAM practices and products that contribute to wellness and health and determine their applicability to health systems and programs, especially in the nation's hospitals and long-term care facilities and in programs serving the aging, those with chronic illness, and those at the end of life.

27.3 CAM and conventional health professional training programs should consider offering training and educational opportunities for students in self-care and lifestyle decision-making to improve practitioners' health and to enable practitioners to impart this knowledge to their patients or clients.

Recommendation 28: Research on the role of CAM in wellness and health promotion, the application of CAM principles and practices, and the role of CAM practitioners in the management of chronic disease should be expanded.

Actions

28.1 The Department of Health and Human Services should fund demonstration projects to evaluate the clinical and economic impact of comprehensive health promotion programs that include CAM. These studies should include underserved and special populations.

28.2 The Federal government and private health organizations should evaluate CAM practices and products that are currently being used for wellness and health promotion to determine their effectiveness and applicability to the management of chronic disease. Funding should be provided for demonstration projects in the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and other Federal agencies for those CAM practices and products found to have benefit in the management of chronic disease, end of life such as hospice.

COORDINATING FEDERAL EFFORTS

Recommendation 29: The President, Secretary of Health and Human Services, or Congress should create an office to coordinate Federal CAM activities and to facilitate the integration into the nation's health care system of those complementary and alternative health care practices and products determined to be safe and effective.

Actions

29.1 The office should be established at the highest possible and most appropriate level in the Department of Health and Human Services and should be given sufficient staff and budget to meet its responsibilities.

29.2 The office should charter an advisory council. Members should include CAM and conventional practitioners with expertise, diverse backgrounds, and necessary training, as well as representatives of both the private and public sectors, to guide and advise the office about its activities.

29.3 The office's responsibilities should include, but not be limited to, coordinating Federal CAM activities; serving as a Federal CAM policy liaison with conventional health care and CAM professionals, organizations, institutions, and commercial ventures; planning, facilitating, and convening conferences, workshops, and advisory groups; acting as a centralized Federal point of contact regarding CAM for the public, CAM practitioners, conventional health care providers, and the media; facilitating implementation of the Commission's recommendations and actions; and exploring additional and emerging topics not considered by the Commission.

List of Acronyms

AAMC: Association of American Medical Colleges

AACOM: American Association of Colleges of Osteopathic Medicine

AANP: American Association of Naturopathic Physicians

AER: Adverse Events Reporting System

AHRQ: Agency for Healthcare Research and Quality

AMA: American Medical Association

BHPr: Bureau of Health Professions

BPHC: Bureau of Primary Health Care

CDCP: Centers for Disease Control and Prevention

CME: Continuing Medical Education

CMS: Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration)

CSPC: Consumer Product Safety Commission

D.C.: Doctor of Chiropractic

DOD: Department of Defense

D.O.: Doctor of Osteopathy

DOEd: Department of Education

DSHEA: Dietary Supplement Health and Education Act

GSA: General Services Administration

FDA: Food and Drug Administration

FSMB: Federation of State Medical Boards

FTC: Federal Trade Commission

GAO: Government Accounting Office

GMP: Good Manufacturing Practices

HIPAA: Health Insurance Portability and Accountability Act

HMO: Health Maintenance Organization

HRSA: Health Resources & Services Administration

IHS: Indian Health Service

IOM: Institute of Medicine

L.Ac: Licensed Acupuncturist

M.D.: Medical Doctor

MEPS: Medical Expenditure Panel Survey

MSOP: Medical Schools Objectives Project

NAS: National Academy of Sciences

NASA: National Aeronautics and Space Administration

NCCAM: National Center for Complementary and Alternative Medicine

NCI: National Cancer Institute

N.D.: Naturopathic Doctor

NHSC: National Health Services Corps

NIH: National Institutes of Health

NLEA: Nutrition Labeling and Education Act

NLM: National Library of Medicine

NSF: National Science Foundation

ODS: Office of Dietary Supplements

OIG: Office of the Inspector General

OMB: Office of Management and Budget

OMH: Office of Minority Health

OSTP: Office of Science and Technology Policy

OWH: Office of Women's Health

PHS: Public Health Service

PPO: Preferred Provider Organization

SAMSHA: Substance Abuse and Mental Health Services Administration

SBA: Small Business Administration

SBIR: Small Business Innovative Research Program

STTR: Small Business Technology Transfer Research Program

USDA: United States Department of Agriculture

USP: United States Pharmacopeia

VA: Department of Veterans Affairs

WHCCAMP: White House Commission on Complementary and Alternative Medicine Policy

WHO: World Health Organization

APPENDICES

Appendix A – Executive Order and Commission Charter

Executive Order 13147

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release March 7, 2000

EXECUTIVE ORDER 13147
WHITE HOUSE COMMISSION ON COMPLEMENTARY
AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), and in order to establish the White House Commission on Complementary and Alternative Medicine Policy, it is hereby ordered as follows:

Section 1. Establishment. There is established in the Department of Health and Human Services (Department) the White House Commission on Complementary and Alternative Medicine Policy (Commission). The Commission shall be composed of not more than 15 members appointed by the President from knowledgeable representatives in health care practice and complementary and alternative medicine. The President shall designate a Chair from among the members of the Commission. The Secretary of Health and Human Services (Secretary) shall appoint an Executive Director for the Commission.
Sec. 2. Functions. The Commission shall provide a report, through the Secretary, to the President on legislative and administrative recommendations for assuring that public policy maximizes the benefits to Americans of complementary and alternative medicine. The recommendations shall address the following:

(a) the education and training of health care practitioners in complementary and alternative medicine;

(b) coordinated research to increase knowledge about complementary and alternative medicine practices and products;

(c) the provision to health care professionals of reliable and useful information about complementary and alternative medicine that can be made readily accessible and understandable to the general public; and

(d) guidance for appropriate access to and delivery of complementary and alternative medicine.

Sec. 3. Administration. (a) To the extent permitted by law, the heads of executive departments and agencies shall provide the Commission, upon request, with such information and assistance as it may require for the purpose of carrying out its functions.

(b) Each member of the Commission shall receive compensation at a rate equal to the daily equivalent of the annual rate specified for Level 1V of the Executive Schedule (5 U.S.C. 5315) for each day during which the member is engaged in the performance of the duties of the Commission. While away from their homes or regular places of business in the performance of the duties of the Commission, members shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701-5707).

(c) The Department shall provide the Commission with funding and with administrative services, facilities, staff, and other support services necessary for the performance of the Commission's functions.

(d) In accordance with guidelines issued by the Administrator of General Services, the Secretary shall perform the functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App.), with respect to the Commission, except that of reporting to the Congress.

(e) The Commission shall terminate 2 years from the date of this order unless extended by the President prior to such date.

WILLIAM J. CLINTON
THE WHITE HOUSE,
March 7, 2000.

# # #

Amendment to Executive Order 13147

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release September 15, 2000

EXECUTIVE ORDER
AMENDMENT TO EXECUTIVE ORDER 13147, INCREASING THE MEMBERSHIP OF THE WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), and in order to increase the membership of the White House Commission on Complementary and Alternative Medicine Policy from not more than 15 members to up to 20 members, it is hereby ordered that the second sentence of section 1 of Executive Order 13147 of May 7, 2000, is amended by deleting "not more than 15" and inserting "up to 20" in lieu thereof.

WILLIAM J. CLINTON
THE WHITE HOUSE,
September 15, 2000.

# # #

Commission Charter

The Commission Charter is only available in hardcopy format.

Appendix B – 10 Rules for Health Care Reform, 28 Focus Areas of Healthy People 2010 and PEW Taskforce Recommendations

10 Rules for Health Care Reform

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1. **Care based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the internet, by telephone, and by other means in addition to face-to-face visits.

2. **Customization based on patient needs and values.** The system of care should be designed to meet the most common types of needs but have the capability to respond to individual patient choices and preferences.

3. **The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decisionmaking.

4. **Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. **Evidence-based decision making.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

6. **Safety as a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. **The need for transparency.** The health care system should make available to patients and their families information that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

8. **Anticipation of needs.** The health system should anticipate patient needs rather than simply reacting to events.

9. **Continuous decrease in waste.** The health system should not waste resources or patient time.

10. **Cooperation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

28 Focus Areas of Healthy People 2010

1. Access to Quality Health Services
2. Arthritis, Osteoporosis, and Chronic Back Conditions
3. Cancer
4. Chronic Kidney Disease
5. Diabetes
6. Disability and Secondary Conditions
7. Educational and Community-Based Programs
8. Environmental Health
9. Family Planning
10. Food Safety
11. Health Communication
12. Heart Disease and Stroke
13. HIV
14. Immunization and Infectious Diseases
15. Injury and Violence Prevention
16. Maternal, Infant, and Child Health
17. Medical Product Safety
18. Mental Health and Mental Disorders
19. Nutrition and Overweight
20. Occupational Safety and Health
21. Oral Health
22. Physical Activity and Fitness
23. Public Health Infrastructure
24. Respiratory Diseases
25. Sexually Transmitted Diseases
26. Substance Abuse
27. Tobacco Use
28. Vision and Hearing

PEW Taskforce Commission Recommendations for Regulation of the Health Care Workforce

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1. States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.

2. States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.

3. States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.

4. States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.

5. Boards should educate consumers to assist them in obtaining the information necessary to make decision about practitioners and to improve the board's public accountability.

6. Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.

7. States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.

8. States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.

9. States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.

10. States should understand the links, overlaps and conflicts between their health care workforce regulatory systems and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes

Appendix C – Commission Meetings

Schedule of Commission Meetings and Material Subjects Reviewed

Commission Meetings
July 13-14, 2000 - Planning Meeting

- Discussion of Vision, Issues and Concerns of the Commission Members on Issues Presented in Executive Order
- Development of Meeting Schedule
- Discussion of Website Development and Content

October 5-6, 2000 - Coordination of CAM Research & Achievements, Opportunities, Obstacles and Solutions

- Public Input and Research Priorities
- Federal Support for CAM Research
- Academic Centers and Support for CAM Research
- Research Support and Collaborations at the NIH
- Facilitating CAM Research and Regulatory Challenges
- Research in the Regulatory Framework
- Outcomes Research - Interface between CAM Research and Regulatory Agencies
- Outcomes Research - CAM Research and Experimental Study Design
- Guiding Principles of CAM Perspectives and Practices
- Support for CAM Research - The Not-for-Profit Sector
- Support for CAM Research - The Private Sector
- Support for CAM Research - Federal Agency Support

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

- Utilization of CAM Services and Products
- Cost Effectiveness of Selected CAM Services
- Clinical Effectiveness of Selected CAM Services
- Use of CAM for Selected Health Conditions
- Issues in Integrating CAM in Service Delivery
- Meeting Public Needs: Systems of CAM Delivery at Community Health Clinics, in Private Practice and Hospital-based Centers, in Hospice Care, at Academic Research Centers and in Managed Care Organizations.

February 22-23, 2001 - Training, Education, Credentialing and Licensing of CAM Practices

- CAM Education and Training: Establishing Educational Programs

- Continuing CAM Education and Training - Building Knowledge and Skills
- CAM Credentialing and Licensure - Assuring Quality and Accountability in CAM Practices

March 26-27, 2001 - Development and Dissemination of CAM Information

- CAM in the Media - Newspapers, Magazines, Television and Radio
- CAM in the Media - The Internet
- Evaluation of available CAM Information
- Marketing and Advertising of CAM Services and Products

March 27, 2001 - CAM in Wellness and Self Care

- Integrative Approaches to Wellness - Children, Families and Communities
- Integrative Approaches to Wellness - Nutrition
- Integrative Approaches to Wellness with Self-Care

May 14-15, 2001 - Coordination of CAM Research

- Not-for-Profit Support for CAM Research
- Investigating the Scientific Bases of CAM Practices
- Approaches to Evaluating CAM Research Literature
- Challenges of CAM Research and Research Training
- Peer Reviews of CAM Research Results in the Published Literature

May 15-16, 2001 - Coverage and Reimbursement of CAM Services

- Health Care Financing in the United States
- Federal Purchasers
- State Perspectives
- Employer Coverage
- The Underinsured, Uninsured and Minorities
- Health Plans and CAM Benefits
- Healthcare Insurance - Providers Perspectives
- Evolving Health Care Systems

July 2-3, 2001 - Discussion of Interim Progress Report

October 4-6, 2001 - Discussion of Draft Recommendations

December 6-7, 2001 - Discussion of Draft Final Report and Recommendations

February 21-22, 2002 - Discussion of Draft Final Report, Recommendations, and Actions

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Town Hall Meetings

September 8, 2000 - San Francisco, CA

October 30-31, 2000 - Seattle, WA

January 23, 2001 - New York City, NY

March 16, 2001 - Minneapolis, MN

Topics Discussed

- Access, Financing and Reimbursement of CAM Practices and Products
- Integration of CAM into Health Care Delivery Systems
- Dietary Supplements and Herbal Products
- Education of CAM Providers
- Education of Health Professionals
- Culturally - Based Healing Traditions
- Regulation of CAM Practices and Products
- Washington State and Minnesota State Legislation of CAM Practices and Products
- Development and Dissemination of CAM-Related Information
- Accountability of CAM Providers

The transcripts, agendas, and other information pertaining to all Commission Meetings and Town Hall Meetings are available on the Commission's website, http://whccamp.hhs.gov.

Appendix D – General and Town Hall Meeting Participants

Planning Meeting
July 13-14, 2000

Peter Reinecke
Senator Tom Harkin's Office

Karen Santoro
National Institute of Allergy and Infectious Diseases

September 8, 2000
Town Hall Meeting
San Francisco, California

Marilyn Schlitz
Institute for Noetic Sciences
CA Pacific Medical Center

Beverly Rubik
Institute for Frontier Science

Catherine Dower
UCSF Center for Health Professions

May Loo
Stanford Medical Center

Deborah Kesten
CA Pacific Medical Center

Corinne Giantonio
Kaiser Permanente

Savely Savva
Monterey Institute for the Study of Alternative Healing

Adam Burke
San Francisco State University

Dana Ullman
Homeopathic Education Services

Craig Little
American Chiropractic Association

Millie Tseng
Santa Clara County Employee Wellness

Lixin Huang
American College of Traditional Chinese Medicine

Bruce Shelton
Arizona Board of Homeopathic Medical Examiners

Kenneth Sancier
Qigong Institute

Peg Jordan
Integrative Health Circles

Michael Mayer
The Bodymind healing Center

Lynn Murphy
Feingold Association of the US

Karen Scott
Progress in Medicine

Stephen Bent
UCSF OSHER Center for Integrative Medicine

Bradley Jacobs
UCSF OSHER Center for Integrative Medicine

Sita Ananth
Health Forum/American Hospital Association

Jan Dederick
East Bay Shen Center

Brian Fennen
Council of Acupuncturists and Oriental Medicine

Carol Ceresa
California Dietetic Association

Anne Kilker

SFVA

Andea Garen
California Dietetic Association

Veny Zamora
Administration on Aging

Cynthia Copple
Lotus Holistic Health

Alex Feng
University of California at Berkeley

Richard Pavek
Shen Therapy Institute

Nicola Henriques
Institute of Classical Homeopathy

Adrian Lowe
Lamas Qigong Association

George Wedemeyer
National Council of Field Labor

Michael Traub
American Association of Naturopathic Physicians

Jay Azarow
Stanford University School of Medicine

Antonio Martinez
American Speciality Health, Inc.

Deane Hillsman
Union of American Physicians and Dentists

Sally Lamont
CA Association of Naturopathic Physicians

Evelyn Lee
Richmond Area Multi-services

Jennifer Bolen
JURIMED

Richard Hansen
Advanced health Research Institute

Ricki Pollycobe
CA Pacific Medical Center

Roy Upton
American Herbal Pharmacopocia

James Underdown
Center for Inquiry

Marc Halpern
California College of Ayurveda

Carla Wilson
Quan Yin Healing Arts Center

Howard Moffet
American College of Traditional Chinese Medicine

Perfecto Munoz
Health Plan of San Joaquin

Len Saputo
Health Medicine forum

Burton Goldberg
Alternative Medicine.com

Karen Ehrlich
CA Association of Midwives

Mitchell Katz
Health Department, City of San Francisco

Harriett Ishimoto
Office of Congresswoman Nancy Pelosi

Catherine Dodd
Department of Health and Human Services, Region X

Steven Ottenstein
Department of Health and Human Services, White House Liason

October 5-6, 2000
Research

Leon Rosenberg
Princeton University

Jeffrey White
Office of Cancer Complementary and Alternative Medicine

Claude Lenfant
National Heart, Lung, Blood Institute, NIH

Marvin Cassman
National Institute of General Medical Sciences

Steven Hausman
National Institute of Arthritis and Musculoskeletal and Skin Diseases, NIH

Paul Coates
Office of Dietary Supplements, OD/NIH

Alfred Fishman
University of Pennsylvania

Daniel Federman
Harvard Medical School

Joseph Pizzorno
Bastyr University

William Meeker
Palmer Center for Chiropractic Research

Stephen E. Straus
National Center for Complementary and Alternative Medicine, NIH

Janet Woodcock
Center for Drug Evaluation and Research, FDA

David Feigal
Center for Devices and Radiological Health, FDA

Joseph A. Levitt
Center for Food Safety and Applied Nutrition, FDA

Christine Lewis
Office of Nutritional Products Labeling and Dietary Supplements, FDA

David Dorsey
Food and Drug Administration (FDA)

Floyd Leaders
Botanical Enterprises, Inc

Robert McCaleb
Herb Research Foundation

Anthony Rosner
Foundation for Chiropractic Education and Research

James Winn
Federation of State Medical Boards of the United States, Inc.

Richard Gonzalez
Private Practice

Ann McCombs
Private Practice

Devi Nambudripad
Private Practice

Jeffrey White
Office of Cancer Complementary and Alternative Medicine, NCI, NIH

John Templeton
The John Templeton Foundation

Dyanne M. Hayes
Conrad N. Hilton Foundation

Daniel Callahan
The Hastings Center

Teri Ades
American Cancer Society

Randy Burkholder
Advanced Medical Technology Association

Raymond Ruddon

Johnson and Johnson

Frank C. Sciavolino
Pfizer, Inc.

Mark Blumenthal
American Botanical Council

Annette Dickenson
Scientific and Regulatory Affairs Council for Responsible Nutrition

Elaine Cramer
National Center for Environmental Health, Centers for Disease Control

Leanna Standish
Bastyr University Research Institute

Lydia Segal
Complementary and Alternative Medicine, Kaiser Permanente (Mid-Atlantic)

Douglas Llyod
Association of Schools of Public Health

John G. Demakis
Health Services Research and Development ServiceVeterans Affairs

William Dietz
Division of Nutrition and Physical Activity, CDC

Michael Trujillo
Indian Health Service

October 30-31, 2000
Town Hall Meeting
Seattle, Washington

Richard Kelley
Department of Health and Human Services, Region X

Robert Harkins
Office of the Insurance Commissioner

Greg Nickels
King County Council, WA

Maggi Fimia

King County Council, WA

Kent Pullen
King County Council, WA

Richard Lyons
US Public Health Service

Dorothy Wong
International Communtiy Health Centers

Gail Zimmerman
WA Department of Health

Henry Ziegler
Private Practice

Kathy Abascal
Botanical Medicine Academy

Lori Bielinski
Office of the Insurance Commissioner

Alonzo Plough
Seattle-King County Health Department

Maggi Fimia
King County Council, District 1

Tom Trompeter
Community Health Centers of King County

Judy Featherstone
Kent Community Health Center

Kathy Lynn Boulanger
Washington Reflexology Association

Pamela Snider
Bastyr University

Leanna Standish
Bastyr University Research Institute

Jeffrey Bland
Institute for Functional Medicine

Richard Hammerschlag
Oregon College of Oriental Medicine

William Dallas
Western States Chiropractic College

Robert D. Mootz
Washington State Labor & Industries

Clyde Jensen
National College of Natural Medicine

Jim Taylor
University of Washington

Karen Sherman
Northwest Institute of Acupuncture and Oriental Medicine

Suzzanne Meyer
Bastyr University

Jacqueline Obando
Mercy Vet PLLC

William E. Lafferty
University of Washington

Charles Simpson
Complementary Healthcare Plans, Inc.

Arlene Darby
Citizens for Alternative Health Care

Nicole Ellis
Personal

Rose Eng-Lum
Dai Wai Association

Jayne Leet
Birdsong Ranch

Daniel J. Labriola
WA State Department of Health

Gay Koopman
Personal

Kathy McVay
WA State Profesioanl Loan Repayment and Scholarship Program

Fred Bomonti
Washington State Chiropractic Association

Laurence M. DeShields
Community Health Center

Tracy Turner
Personal

John Stephen Huber
Highline Community College

M. Jacobson
Personal

Laura Patton
Group Health Cooperative of Puget Sound

Elizabeth Goldblatt
Commission on Colleges, A/OM Accrediting Agency

JoAnne Myers-Ciecko
Seattle Midwifery School

Susan Haeger
Citizens for Health (National)

Michelle Simon
Personal

Julie Chinnock
Personal

Chris LePisto
Personal

Don Taylor
Personal

Cindy Breed

Community Health Centers of King County

Jane Guiltinan
Natural Medicine Clinic, Bastyr University

Fernando Vega
Seattle Healing Arts Clinic

Judith Aileen Kaufman
Emerald City Healing Arts

Stan Lippmann
Natural Medicine Party

Valerie Sasson
Puget Sound Birth Center

Scott Barnhart
University of Washington

Leah Kliger
Evergreen Community Health Center

Brenda Loew
Japanese Acupuncture Center

Robert A. May
Alternare Health Services

Terry Courtney
Bastyr University

Sue Vlasuk
DABCO

Diana Thompson
Private Practice

Houston LeBrun
American Message Therapy Association

Heike Doyle
Puget Sound Midwives & Birth Center

Jerri Fredin
Citizens for Alternative Healthcare

Don Sloma
Private Practice

Robert Nicoloff
WA State Department of Health

Richard Whitten
Washington Health Care Authority

Andrew John Brunskill
Uniform Medical Plan, Health Care Authority

Karl D. Peterson
NW Naturopathic Physicians Convention

Pat Prinz
U WA School of Nursing

Kay Lahdenpera
Personal

Jane Bernice Nelson
North Bend Elementary

Sheila Kennedy Rhodes
Mt. Baker Care Center

Vera Ridderbusch
Private Practice

Katherine R. Schmidt
Bellevue Massage School

Ronald Schneeweiss
University of Washington

Paul Saunders
Office of Natural Health Products

Karta Purkh Khalsa
Personal

Jennifer Jacobs
American Institute of Homeopathy

Emma Bezy
Spirituality Program, Bastyr University

Tom Shepherd
Bastyr University

Robert Arthur Anderson
American Board of Holistic Medicine

Charlotte Coon
Hellerwork International

Jeffrey Goin
Coalition for Natural Health

Barbara Mitchell
Standards Management, Inc.

Mark Tomski
Washington Chapter of the AAMA

Christa Louise
North American Board of Naturopathic Examiners

Todd L. Richards
University of Washington

Lise Alschuler
Bastyr University

Jeff Novack
Bastyr University

Sevak S. Kroesen
Integrative Health Care Center, Inc.

Robert Shook
Northwest Institute for Acupuncture & Oriental Medicine

Tommy Lewis
Northwest Indian College

Ralph Forquera
Seattle Indian Health Board

Graham Patrick

Seattle University School of Nursing

Wayne William Topping
Topping International Institute, Inc.

Wendy J. Weber
Personal

Heida Brenneke
Brenneke Massage School

Paul Reilly
WANP, AANP

John Daley
Private Practice

Eileen Stretch
American Whole Health Network

Jennifer Booker
American Association of Naturopathic Physicians

Victoria M. Taylor
Quality Midwifery Associates

Austin McMillin
Private Practice

Susan Rosen
American Massage Therapy Association

Sheila Quinn
King County Integrated Health Care 2010

David Matteson
Pacific Solutions

James K. Rotchford
Medical Acupuncture Research Foundation

Mitch Stargrove
Integrated Body/Mind Information System

Bradford S. Weeks
Well Mind Association

David A. Butters
Personal

Christopher Huson
Acupuncture Association of Washington

December 4-5, 2000
Access and Delivery

William Meeker
Palmer Center for Chiropractic Research

Konrad Kail
Private Practice

Patricia Culliton
Hennepin County Medical Center

Joyce Frye
National Center for Homepathy

Tiffany Field
University of Miami School of Medicine

Dennis Awang
Medi Plant Consulting Services

Christopher Hobbs
Institute for natural Products Research

Alan Gaby
Bastyr University

Patsy Brannon
College of Human Ecology, Cornell University

Harley Goldberg
Kaiser Permanente, Northern California

Francine Butler
Association for Applied Psychophysiology and Biofeedback

Nancy Dolores Kolenda
Center for Frontier Sciences

Diana Chambers
Friends of Health

Rustum Roy
University of Arizona-PIM

David Murray Blalwas
Maryland Acupuncture Society

Kathleen Golden
Acupuncture Society of New York

Natalia Egorov
California Oriental Medical Association

David Edgar Molony
American Association of Oriental Medicine

Elaine Marie Wallzer
Henry M. Jackson Foundation

Bhavna P Bhut
OJAS Cancer Care Institute

Neeta Kunai Suryavanshi
Aspen Systems

Salvatore A D'Onofrio
Natural Health Practitioners Board

Howard Josepher
Private Practice

Denise Drayton
Personal

Jeanne Andrews
Personal

Richard Collins
Allegent Health Heart Institute

Walter Czapliewicz
Personal

J. Donald Schumacher
The Center Hospice and Palliative Care

Richard Miles
Health Frontiers

Berkley Bedell
The National Foundation for Alternative Medicine

Paul Kurtz
State University of New York-Buffalo

Donald Kendall
National Guild of Acupuncture and Oriental Medicine

Candace Campbell
American Preventive Medical Association

Michele Forzley
Forzley and Company

Robert Atkins
Atkins Center for Complementary Medicine

Charlotte Eliopoulos
American Holistic Nurses Association

Mort Rosenthal
Wellspace, Inc.

Dannion Brinkley
Compassion in Action

Tom Trumpeter
Community Health Centers of King County

Sylver Quevedo
Center for Integrative Medicine

Woodson Merrell
Continuum Center for Health and Healing

James Dillard
Oxford Health Plans

Lori Bielinksi

Office of the Washington State Insurance Commissioner

Anna Silberman
Lifestyle Advantage

Robert Schneider
Maharishi University of Management

Tori Hudson
A Woman's Time

Robert Duggan
Traditional Acupuncture Institute

Bruce Nordstrom
American Chiropractic Association

Neal D. Barnard
Physicians Committee for Responsible Medicine

Doreen Chen
Chinese Medicine Council, AAOM

Gary Sandman
Integrative Medicine, LLC

Danny Freund
Pennsylvania State University

Melinna Giannini
Alternative Link

Jane Hersey
Feingold Association

Boyd Landry
The Coalition for Natural Health

Lawrence Auburn Plumlee
National Coalition for the Chemically Injured

Michael John Rohrbacher
Certification Board for Music Therapists, Inc.

Andrew L. Rubman
American Association of Naturopathic Physicians

Marshall H. Sager
American Academy of Medical Acupuncture

Alan Trachtenberg
Substance Abuse and Mental Health Administration

Bridget Duffy
Medtronic

Milton Hammerly
Catholic Health Initiatives

January 23, 2001
Town Hall Meeting
New York, New York

Ansel R. Marks
New York State Department of Health Board of Professional Medical Conduct

Margaret B. Buhrmaster
NYS Department of Health, Office of Regulatory Reform

Caroline V. Rider
Personal

Stephen Lee Lockwood
Lockwood & Golden, Esqs.

Simone Charlop
Personal

Martin Rossman
Academy for Guided Imagery

Grace Marie Arnett
The Galen Institute

Camilla R. G. Rees
Strategic Communications Counsel

Joseph Loizzo
Columbia Presbyterian Eastside

Kevin Chen
UMDNJ - New Jersey Medical School

Leo Galland
Foundation for Integrated Medicine

Fredi Kronenberg
Rosenthal Center for Complementary and Alternative Medicine

Elaine Stern
Personal

Kerri Ann Gruninger
Rosenthal Center

Frank Lipman
Personal

Faye Shenkman
The New York College for Wholistic Education and Research

Carole Sherri Margalit
SHARE

Ann E. Fonfa
The Annie Appleseed Project

Cecile Schey
Personal

Johanna Frances Antar
Personal

David E Molony
American Association of Oriental Medicine

David Yens
NY College of Osteo Medicine

Prabhat Jumar Pokhrel
New York College for Wholistic Health , Education and Research

Jennifer Daniels
Family Medicine, Solo Practice

Charles E. Gant

Personal

Serafina Corsello
Corsello Centers for Alternative Medicine

Arnold Gore
Consumers Health Freedom Coalition

Edna Fishman
Personal

Helen Choat
Personal

Janet Susan O' Faolain
New York State Reflexology Association

Vera C. Smith
Personal

Monica Miller
Foundation for the Advancement of Innovative Medicine (FAIM)

Phillip Shinnick
Personal

Patricia Connolly
Personal

Gary Wadler
Physician/Author for Peak Performance Issues

Renate Siekmann
Personal

Sheldon Lewis
for Healers.com

Sally Kimball Ekaireb
NYNHC

Jordana Sontag
Personal

James Navarro
Personal

Jordi Ross
Documentary Filmaker

Robert Schiller
Beth Israel Medical Center

Ellen Paula Tattleman
Albert Einstein College of Medicine

David Katz
Yale School of Medicine

William Prensky
Mercy College

Kenneth Steven Gorfinkle
Columbia University/New York

Constance Park
Columbia University College of
Physicians and Surgeons

Mark L. Hoch
American Holistic Medical Association

Fran Catherine Starr
American Holistic Nurses Association

Sally Bishop
Mt. Sinai Hospital

Bhaswati Bhattacharya
American Public Health Association

Pamela Miles
Institute for the Advancement of Complementary Therapies

Brian J. MacNamara
Personal

Andrew L. Rubman
University of Bridgeport

Mark W. Garber
Greenwich Hospital

Bronner Handwerger
University of Bridgeport

Jonathan A. Daniel
Pacific College of Oriental Medicine

Steven Schenkman
The New York College for Wholistic Health Education and Research

Michael Charles Gaeta
New York College for Wholistic Education and Research

Kathleen Ann Golden
Acupuncture Society of NY

Donald D'Angelo
American Society of Acupuncture

Tsao-Lin E. Moy
Tri-State College of Acupuncture

Huaihai Shan
University of Medicine & Dentistry of New Jersey

Christopher Kent
Council on Chiropractic Practice

James Dillard
Columbia University College of Physicians and Surgeons

Barrie R. Cassileth
Memorial Sloan-Kettering Cancer Center

Raymond Y. Chang
Institute of East-West Medicine

Janice Pingel
Personal

Joan Framo Runfola
Cancer Care

Barbara Sarah
Benedictine Hospital

Virginia Mae Langley
The Coalition for Natural Health

Robb Burlage
National Council of Churches

Swami Sada Shiva Tirtha
Ayurveda Holistic Center

Ellen H. Schaplowsky
Traditional Chinese Medicine World Foundation

Ming Jin
MingQi Natural Healthcare

Thomas Leung
Association of Chinese Herbalist

Sezelle Gereau-Haddon
The Riverside Church Wellness Center

Frances L Brisbane
School of Social Welfare
Ora J. Bouey
SUNY at Stony Brook, School of Nursing

Elsie Owens
School of Social Welfare

Eliza Townsend
Private Practitioner

Charles L Robbins
School of Social Welfare

Dan Kamofsky
Care for the Homeless

Maria Josepher
Exponents Inc

John Tribbie
Greyston Health Services

Anthony Vera
Betances Health Center

Anne Markowitz
Center for Victim Support, Harlem Hospital

Pamela A. Maurath
Midwifery Task Force

Sharon S. Reilly
Friends of Midwives in Connecticut

FeiLong Qi
World Shaolin Chanmigong Association

Yi Lin Hu
United Alliance of New York State

David KM Lew
The Acupuncture Center

Ding Peng
T.C.M.A.

Phyllis W. Tan
BMK International Inc.

Ruth Hillman
New York Oriental HealthCare Center

Victor Fuhrman
Independent Reiki Master

Ellen Louise Kahne
Rejki University-Reiki Peace Network, Inc.

Robbie Fian
American Association of Oriental Medicine

Missy Vineyard
American Society for the Alexander Technique

Martha Hart Eddy
International Somatic Movement Education and Therapy Assocation

Jodi Danielle Sherman
SUNY Downstate

Bruce L. Erickson
B. L. Erickson & Associates

Cassandra Lockwood
International Somatic Movement Education and Therapy Assocation

Patrick Gentempo
Chiropractic Leadership Alliance

Peter Bruce Flaum
T-CAM

Ken Frey
The Upledger Institute

Sidney Safron
Natural Medicine Practice

James H. Budd
Personal

Karen Fuller
Personal

Martin Vincent McCarthy
The Health Accord

Kathleen Ann Lukas
New York Natural Health Coalition

Rachel Lee Chaput
Green Party

Kimberleigh Nystrom
Resonance Homeopathic Study Group

Anthony G. Bloch, BA
Personal

Lawrence Galante
Lawrence Galante's School of Tai Chi Chuan

Jeffrey R. Goin
Coalition for Natural Health

Ulises Vargas

Coalition for Natural Health

Ridgely Ochs
Newsday

Ellen J. Schutt
Nutraceuticals World

Peter Chowka
Publick Occurrences.com

Chao Chyan Pai
AcuMD.COM

Hannah Vance Bradford
CAM Communications and Reports

Diane McEnroe
Sidley & Austin - National Nutrional Foods Association

Theresa Marie Warner
World Childrens Wellness Foundation

Stuart Peter Warner
World Childrens Wellness Foundation

Belinda Arocho
Personal

Francis Lane Rosenbluth
Personal

Yvonne R. Secreto
The Respit Foundation and Wholistic Professionals Inc.

Pauline Ness
The Respit Foundation and Wholistic Professionals Inc

Judy Schneider
Feingold Association of the United

Kathleen Bratby
Feingold Association

Sandra Ehrenkranz
Feingold Association

Ludwig Duarte Anaya
Association of the Homeopathy in Colombia, South American

Diego E. Sanchez
AOBTA

Magnolia Goh
Highbridge Woodycrest Center

Pierre Rene Fontaine
New York Natural Health Coalition

February 22-23, 2001
Education and Training

Louis H. Orzack
Rutgers University

Jennifer Engstrom
Case Western University
Deborah Danoff
Association of American Medical Colleges

Peter Scoles
National Board of Medical Examiners

Alfred Fishman
University of Pennsylvania

Polly Bednash
American Association of Colleges of Nursing

Neil Sampson
Health Resources and Services Administration

Sara Collina
National Breast Cancer Coalition

Joseph Helms
American Academy of Medical Acupuncture

Lixing Lao
Institute of Traditional Chinese Medicine

Mark Blumenthal
American Botanical Council

Denise Murray . Edwards
Center for Health and Well-Being

Susan South
University of Arizona

Murray Kopelow
Accreditation Council of Continuing Education

Michael Cohen
Center for Alternative Medicine Research and Education

Boyd Landry.
Coalition for Natural Health

Sharon Hall
Washington Casualty Company

Steven Olson
American Massage Therapy Association

Clement Bezold
Institute for Alternative Futures

James Winn
Federation of State Medical Boards

Susan Silver
George Washington Center for Integrative Medicine

Margaret Huddleston
Harvard Divinity School

Robert Scholten
Beth Israel Deaconess Medical Center

Rustum Roy
Pennsylvania State University

Diane Miller
National Health Freedom Coalition

Susan Bonfield Herschkowitz
Self Representation

Colleen Smethers
Progress in Medicine Foundation

Michele Forzley
Attorney at Law

Victoria Mary Goldsten
Washington Institute of Natural Health

Brenda Jasper
Association of Physician Assistant Programs

Emily WhiteHorse
Association of Physician Assistant Programs

Ingrida Lusis
American Chiropractic Association

Brian McAulay
Sherman College of Straight Chiropractic

David Molony
American Association of Oriental Medicine

Kathleen Quain
Foundation for Health and the Environment

Shula Edelkind
Progress in Medicine Foundation

Karen Scott
Progress in Medicine Foundation

Christina Walker
Schenk Human Energetic Institute

Chi Chow
New York Institute of Chinese Medicine

George Krutz
Feldenkrais Guild of North America

March 16, 2001
Town Hall Meeting
Minneapolis, Minnesota

Frank Bernard Cerra
University of Minnesota

Chris Foley
HealthEast

Roger Chizek
Medtronic

James Woodburn
Blue Cross Blue Shield of MN

Patricia Culliton
Alternative Medicine Clinic

Lynn M. Lammer
Homeopathic Consultants, Inc

Sharon Norling
Mind Body Spirit Clinic, Fairview Health Systems

Julie Schmidt
Woodwinds Health Campus

Timothy P. Culbert
Children's Hospitals and Clinics

Carolyn Joyce Torkelson
Bush Fellowship Program of Study

Kathy Ann Schurdevin
President, MN Natural Health Legal Reform Project

Matthew Yavner Wood
American Herbalists Guild

Jodi A Chaffin
MN Pharmacists Association and HealthPartners

Richard Leon Kingston
UoMN/PROSAR Intl Poison Center

John Mastel
Natural Foods Store

R. William Soller
Consumer Healthcaree Products Association

Margery A. Wells
American Association of Oriental Medicine

Val Ohanian
Northwestern Academy of Homeopathy

Jackson Petersburg
Director: Center Point

Barbara York
Minnesota Touch Movement Network

Rose Haywood
MN College of Acupuncture and Oriental Medicine of Northwestern Health Sciences University

Michael Green
Personal

Mary Jo Kreitzer
University of Minnesota

Bill David Manahan
Center for Spirituality and Healing

Erin Colleen O'Fallon
University of Minnesota Medical School

Patricia Cole
Director of Family Practice Residency: Hennepin County Medical Center

Mary Buntrock Johnson
St. Olaf College

Janet Dahlem
Wholistic Nurses Association, University of St. Catherine's

Robert Patterson
University of Minnesota

Janice E. Post-White
University of Minnesota

Christopher James Hafner
Cloud River

Mary Ellen Kinney
United Hospital

Milton Seifert
Eagle Medical

Frank Dennis Wiewel
People Against Cancer

Okokon Udo
Center for Cross-Cultural Health

Michele Denize Strachan
Powderhorn-Phillips CulturalWellness Center

Thupten Dadak
Tibetan American Foundation of Minnesota

Chunyi Lin
Founder: Spring Forest QiGong, Inc.

Jose Reyes
Itzamatul Itolixtli Danzantes

Sabina Pello
American Association of Immigrants from the former USSR (IL Branch)

Tom R Hiendlmayr
Minnesota Department of Health

Michael Myers
University of South Dakota

Michael Morris Kleiner
University of Minnesota

Rob Leach
Executive Director: Board of Medical Practice

Marillyn Beyer
Natural Health Coalition

Rebecca Frost
International Somatic Movement Education and Therapy Association

Diane Miller
National Health Freedom Coaltion

Lynda Boudreau
A Representative of the Minnesota House of Representatives

Ms. Brekken
Minnesota Board of Nursing

Stephen T. Bolles
NW Health Sciences University

Helen Catherine Healy
Minnesota Association of Naturopathic Physicians

Jerri Johnson
MN Natural Health Coaltion

Susan Marie Hageness
Children's Hospitals and Clinics

Pamela Lou Ahrens
Children's Hospitals and Clinics

Bob Michael Barron
Wellness Educators

Kate S. Birch
Minnesota Homeoapthic Assosiation

Ann Catherine Richtman
Northland Natural Health Resources, Inc.

Tenby Owens
St. Luke's Center for Holistic HealthCare

Howard Fidler
American Chiropractic Association

John E. Toft

Functional Medicine Chiropractic Center

Marilynn Rose Anderson
The Feldenkrais Guild of North America

Chu Yongyuan Wu
Hmong Shaman Research Project

Jeffrey Dusek
Mind/Body Medical Institute

Richard Rainbow Pavek
The SHEN Therapy Institute

Larry Paul Caldwell
Acupunture Association of Minnesota

Zhaoping Li
MN College of Acupuncture and Oriental Medicine
Northwestern Health Sciences University

Changzhen Gong
American Academy of Acupuncture

Jennifer Blair
Acupuncture Association of MN

Ike Rodman
College of Acupuncture and Oriental Medicine
Northwestern Health Sciences University

Gregory Vernon Schmidt
MN Natural Health Legal Reform Project

Leo Bernard Cashman
MN Natural Health Legal Reform Project

Amrit Devgun
Santulan Health Center

Gayle Bowler
Minnesota Natural Health Coalition

Jeanne Hollingsworth
Minnesota Natural Health Coalition

Nancy Gay Hone
Minnesota Natural Health Coalition

March 26, 2001
Information Dissemination and Wellness

Irene Liu
National Institute of Health

Sheldon Kotzin
National Library of Medicine

Dale Ogar
University of California

Burton Goldberg
Alternative Medicine.com
Peter Chowka
Natural Health Line

Andrew Weil
Ask Dr. Weil

Craig Stoltz
Washington Post

Sara Altshul
Prevention Magazine

Christine Gorman
Time Magazine

Susan Schiller
CBS Evening News

Joe Neel
National Public Radio

Elmer Huerta
Prevencion

Harrison Rainie
Pew Internet and American Life Project

Susan Detwiler
The Detwiler Group

V.Srini Srinivasan
U.S. Pharmacopeia

Lucinda Maine
American Pharmaceutical Association

David Schardt
Center for Science in the Public Interest

Christopher Hendel
Consumer Reports

Michelle Rusk
Federal Trade Commision

Christine Lewis
U.S. Food and Drug Administration

Sarah Taylor
Covington & Burling

William Soller
Consumer Healthcare ProductsAssociation

Mark Land
Boiron Homeopathic Products

John Astin
University of Maryland

Adrian Sandler
American Academy of Pediatrics

Marc Micozzi
College of Physicians, Philadelphia

David Larson
National Institute of Healthcare Rearch

Walter Willett
Harvard School Public Health

Kate Gordon
American Dietetic Association

Michio Kushi
Kushi Institute

Jeffrey Bland
Metagenics

Mark Hyman
Canyon Ranch

Frances Brisbane
SUNY at Stony Brook School of Social Welfare

Cathy Moxley
Marriott International, Inc.

Karen Prestwood
University of Connecticut Health Center

Christina Puchhalski
George Washington University School
of Medicine

Michael Zeng
International Institute of Chinese Medicine

David Edgar Molony
American Association of Oriental Medicine

Marcellus Andre Walker
africanamericanhealth.com

Diana Chambers
Friends of Health

Robert Miller
First Church of Christ, Scientist

Kathleen Mary Quain
Foundation for Health and the Environment

Donald Epstein
Association for Network Care

Paula Kim
Pancreatic Cancer Action Network

Jennifer Roe
American Association of Naturopathic Physicians

Scott Lamp
American Message Therapy Association

George Krutz
Feldenkrais Guild of North America

John Philip Adams
Self

Bruce Nordstrom
American Chiropractic Association

John D. Melnychuk
California Health Freedom Coalition

May 14-16 2001
Reimbursement

Michael O'Grady
Project Hope, Center for Health Affairs

John Whyte
Health Care Financing Administration

Abby Block
Office of Personnel Management

Joy Johnson Wilson
National Conference of State Legislators

Merilyn Francis
American Association of Health Plans

Alan Korn
Blue Cross and Blue Shield Association

Tom Sawyer
William M. Mercer, Incorporated

Kathleen King
Washington Business Group on Health

Judith MacPherson
CACI International Inc.

Derrick Gallion
Blue Cross Blue and Shield of South Carolina

John Kelly
Aetna/U.S. Healthcare

John Weeks
Integration Strategies for Natural Health Care

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Draft Report

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Pivate Citizen

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Progress on Final Report

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Draft Final Report

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Appendix E – Organizations Providing Information on Education and Training of Health Care Professionals

Academy of General Dentistry
Academy of Guided Imagery
Accreditation Commission for Acupuncture and Oriental Medicine
Accreditation Council for Continuing Medical Education
Accreditation Council for Graduate Medical Education
Agency for Healthcare Research and Quality
American Academy of Craniofacial Pain
American Academy of Family Physicians
American Academy of Pain Management
American Academy of Pediatrics
American Academy of Physician Assistants
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Diabetes Educators
American Association of Medical Acupuncture
American Association of Naturopathic Physicians
American Association of Oriental Medicine
American Association of Pastoral Counselors
American Board of Medical Acupuncture
American Board of Medical Specialties
American Chiropractic Association
American College of Clinical Pharmacy
American College of Health Care Administration
American College of Nurse Midwives
American College of Obstetricians and Gynecologists
American College of Osteopathic Obstetricians and Gynecologists
American College of Physicians/American Society of Internal Medicine
American Dietetics Association
American Herbalists Guild
American Holistic Dental Association
American Holistic Health Association
American Holistic Medical Association
American Holistic Nurses Association
American Institute of Homeopathy
American Massage Therapy Association
American Medical Association
American Medical Students Association
American Nurses Association
American Occupational Therapy Association
American Organization of Bodywork Therapies of Asia
American Osteopathic Association

American Pharmaceutical Association
American Physical Therapy Association
American Polarity Therapy Association
American Psychological Association
American Public Health Association
American Qigong Association
American Society for the Alexander Technique
American Society of Health-System Pharmacists
Association of American Indian Physicians
Association of American Medical Colleges
Association of Applied Psychophysiology and Biofeedback
Association of Physician Assistant Programs
Association of Professional Chaplains
Association of Professors of Gynecology and Obstetrics
Association of Schools of Public Health
Barbara Brennan School of Healing
Bureau of Health Professionals, HRSA
Complementary Medicine Program/University of Maryland
Council of Colleges of Acupuncture and Oriental Medicine
Council of Osteopathic Student Government Presidents
Duke Center for Integrative Medicine
Federation of State Medical Boards of the United States, Inc
Federation of Straight Chiropractors and Organizations
Feldenkrais Guild of North America
Hellerwork International
Hospice and Palliative Nurses Association
Institute of Medicine, National Academy of Sciences
International Chiropractic Association
Joint Commission on Accreditation of Healthcare Organizations
Josiah Macy Jr. Foundation
Kawaikapuokalani K. Hewitt
National Association for Holistic Aromatherapy
National Association of Social Workers
National Black Nurses Association
National Board of Medical Examiners
National Board of Osteopathic Medical Examiners
National Center for Homeopathy
National Certification Commission for Acupuncture and Oriental Medicine
National Commission on Certification of Physician Assistants
National Committee for Quality Assurance
National Dental Assistants Association
National Health Service Corps (HRSA, BPHC)
National Qigong Association
Nurse Healers-Professional Associates International
Office of Dine [Navajo] Culture, Language, and Community Services
Papa Ola Lokahi

Pew Charitable Trusts
Program in Integrative Medicine/University of Arizona
Reflexology Association of America
Society for Public Health Education
Student Osteopathic Medical Association
The Continuum Center for Health and Healing/Beth Israel Medical Center/
The Oncology Nursing Society
The Rolf Institute of Structural Integration
Upledger Institute
World Chiropractic Alliance
Yoga Alliance

Appendix F – White House Commission on Complementary and Alternative Medicine Policy Workgroup Members

COMMISSION WORKGROUPS AND MEMBERS

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George M. Bernier, Jr., M.D.
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Appendix G – Statement from Commissioners

LETTER FROM JOSEPH FINS, M.D. AND TIERAONA LOW DOG, M.D.

March 10, 2002

The Honorable Tommy G. Thompson
Secretary, Health and Human Services
Washington, DC 20201

Dear Mr. Secretary:

We would like to thank the American public for allowing us to serve on the White House Commission on Complementary and Alternative Medicine Policy. The Commission struggled with many complex issues and the final report reflects the enormous effort and hard work of the Commissioners and staff. We support many of the Commission's recommendations and appreciate the efforts to accommodate a diversity of views and achieve a consensus. Nonetheless, we feel it necessary to write this additional statement to provide clarification as these recommendations are considered for implementation. These are views we have stated consistently throughout the Commission's twenty months of deliberations.

The Executive Order 13147 directed that The White House Commission on Complementary and Alternative Medicine (CAM) Policy "shall provide a report, through the Secretary, to the President on legislative and administrative recommendations for assuring that public policy maximizes the benefits to Americans of complementary and alternative medicine."

While many of the Commission's recommendations will help maximize the benefits of proven safe and effective approaches, practices and products, they do not appropriately acknowledge the limitations of unproven and unvalidated "CAM" interventions or adequately address the minimization of risk.

In this statement we will seek to be specific in our critique about these risk/benefit questions. In this effort we hope to give voice to the healthy skepticism that exists in many sectors of American public life with regard to complementary and alternative medicine, a perspective that may not have been adequately represented in the constitution of the Commission or in the testimony that we heard.

1. Acknowledging the Limitations of Unproven CAM Interventions While the

Report acknowledges that much of what is considered "CAM" has not been

shown to be safe and effective, a presumption exists that complementary and alternative medicine will be found to be beneficial. This advocacy tone persists in the Report despite great efforts to achieve editorial balance. Despite qualifying statements added to the Introduction of the Report -- which we endorse -- the body of the document continues to give voice to a perspective that suggests that most "CAM" interventions will be proven to be safe and effective through scientific research. Last minute revisions to the Introduction do not mitigate more global statements that permeate the Report. There continues to be language suggesting that "CAM" will lead us into a new paradigm of health care that will provide answers for those with chronic disease, as well as our aging and under-served populations. We will discuss these concerns in the context of research priorities, access and the underserved, the provision of primary care services and medical education.

1.1 Research Priorities

We strongly endorse the need for more research; however, we recognize that research dollars are finite. The Commission's lack of a prioritization strategy for research initiatives, given the many areas that "CAM" encompasses, makes a general endorsement of research of limited value. Promising areas of research should be investigated because they potentially have something to offer to the health of the American people or because they advance our scientific understanding of illness and healing. Asking for more research money to investigate an approach, practice or product simply because it is "CAM" is an ideological, not evidence-based approach to science. Recommendations for research on "frontier areas of science" without a strategy for building this research on scientific foundations may result in spending precious health care research dollars on areas that are unlikely to yield any beneficial data such as "iridology", "psychic healing" et. al. While dogmatic disbelief of everything that is not currently explainable is foolish, and indeed unscientific, it seems equally foolish to ask the taxpayer to bear the enormous expense of sorting out those areas that are plausible from those that are improbable.

With sound research priorities in mind, we feel it is important to point out that many of the recommendations made in the research and access sections of the Report are already being undertaken by NCCAM, a Center within the National Institutes of Health. NCCAM has established fifteen specialty research centers that cover "CAM" approaches for many areas of major public health need. These centers are focused on studying the underlying mechanisms of "CAM" modalities, cancer treatments, "CAM" for end-of-life care, botanicals, the use of "CAM" therapies to reduce health disparities and integrative medicine.[i] Given the concentration of expertise and existing infrastructure at NCCAM, recommendations for a wide sweeping "CAM" research agenda to be implemented across a large number of federal agencies does not appear to be a cost-effective or logical way to make progress.

1.2 Access and the Underserved

When the Commission sought to be inclusive by expanding access to "CAM" products, providers and modalities to underserved populations through demonstration projects or other programs it did not adequately appreciate that these recommendations were being made for populations which have limited or no access to conventional medical care. In this context, the provision of "CAM" becomes neither a complementary nor integrative intervention, but rather a less validated alternative to conventional care. The Commission heard testimony that many underserved populations utilize folkloric or "CAM" interventions because they cannot afford access to conventional care.[ii] It is worth considering whether these individuals would prefer a drug benefit over access to unproven supplements or if they would seek out "CAM" providers if they had the resources to receive care from primary care practitioners. Given the state of the science, most "CAM" interventions can only be said to add to and not replace conventional interventions. A consideration of "CAM" entitlements or an expansion of insurance benefit packages is one thing in the context of preexisting access to conventional medical care. It is ethically quite another in the absence of such coverage.

While there is room for diversity in the health care system, we should not be a party to creating a separate but unequal care system. It is our strong belief that we should provide basic health care to every American before expanding benefits to include treatments or approaches that have not been shown through rigorous research to treat or prevent disease. We must never foster a second-tier of medical care for those who are economically disadvantaged.

1.3 Primary Care Practitioners

The Commission debated at great length whether or not we would recommend that "CAM" practitioners be included in loan-forgiveness and scholarship programs, especially as it relates to their possible inclusion in the National Health Service Corps. The Report carefully delineates the eligibility requirements for inclusion in this program and why Title VII of the Public Health Services Act does not recognize "CAM" practitioners as primary care providers eligible for inclusion in this program. While we endorse demonstration projects that seek to identify what, if any, value "CAM" providers add to established primary care teams, we want to go on record noting that we do not believe that CAM providers are fungible with the primary care providers enumerated in Title VII. This concern does not mean that some CAM practitioners do not have the potential to add to the public health or meaningfully affect the lives of patients. It is simply that they are not positioned for equivalency with conventional primary care providers. Efforts to equate their degree of training, or the scientific basis of their practice, with that of the designated primary care specialties puts the public at risk of receiving unvalidated and non-evidence based primary care.

1.4 Education and Training of Conventional Practitioners

Conventionally trained health care practitioners must be able to dialogue with their patients about a wide variety of topics including sexuality, domestic violence, substance abuse, spirituality, death and dying, pain, emotional health and non-conventional therapies. We strongly support the need for health care providers to be able to critically assess the evidence for approaches, practices and products that their patients may be using, however, most medical schools (approximately 72%) already teach courses on what is considered "CAM". If the critique is that conventional medical curricula are lacking in areas such as nutrition, self-care instruction or preventive medicine, the appropriate response is to improve the teaching of this subject matter. Furthermore, as medical educators we believe that recommendations for curricular reform will be better received if they are not cast in language that implies a mandate. Whatever is included in the medical curriculum must remain true to scientific integrity, avoid ideological indoctrination and guard against teaching unproven treatments to the next generation of health care providers.

2. The Minimization of Risk

To fully meet the spirit of the Executive Order, the Report would need to do more than identify the benefits to be maximized. It would also need to avoid the assumption of avoidable risk, especially when the benefits are uncertain and the risks are clear. We will now comment on how the Report's lack of definitional clarity limits appropriate risk management, address public preferences regarding regulation and consider the special concerns of vulnerable populations.

2.1 Lack of Definitional Clarity

Addressing the risks or benefits associated with "CAM" interventions is difficult because the recommendations suffer from a lack of specificity. Generic recommendations neither serve the public interest nor protect the public health because they fail to distinguish between approaches, practices and products for which there is some scientific evidence and those that either stretch the realm of logic or are demonstrably unsafe. The Report's inability to discriminate amongst "CAM" practices, products and practitioners leaves its recommendations open to interpretation. This limits their applicability as public policy.

The Report's lack of definitional clarity undermines the legitimacy of safe and effective non-conventional approaches by failing to distinguish them from treatments that are improbable or fraudulent. For instance, there is strong evidence that relaxation therapies help reduce chronic pain in patients with a variety of medical conditions.[iii] Glucosamine sulfate has been found superior to placebo for the treatment of osteoarthritis.[iv] However, chelation therapy has not been shown to be beneficial for the treatment of ischemic heart disease,[v] though is still promoted as a treatment. Alternative diets, coffee enemas, ozone therapy,

and shark cartilage offer little for cancer patients, however, acupuncture, aromatherapy, and meditation may be useful for nausea/vomiting, mild relaxation, and pain/anxiety, respectively.[vi]

The Report's inclusion of all "CAM" practices, without appropriate nuance, fails to adequately appreciate the heterogeneity of these practices. This omission undermines those areas within CAM that have already demonstrated safety and efficacy and may be ready for integration into the healthcare system.

Wellness and Health Promotion

"Promoting wellness", "health promotion" and "prevention practices" are phrases that recur throughout the Report and are cited as being the focus of many "CAM" approaches. It is unclear what these terms actually mean, as no clear examples are provided in the document. If it means that one can enhance his or her sense of well being through a healthy diet, regular exercise and other lifestyle modifications, there is little debate. There is a large body of evidence for the beneficial role of nutrition, exercise and stress management in the scientific literature. The Commissioners debated the inclusion of these lifestyle approaches under "CAM" and the final Report acknowledges that these approaches are found in both "CAM" and conventional medicine, but claims that there is a "greater emphasis" placed upon them in "CAM." One has only to visit the local book store to find the numerous "fad" diet books that fall under "CAM" nutrition; high fat - high protein diets, eat according to your blood type diets and fruitarian diets, to name a few. There is no single "CAM" nutritional approach. In addition, if one were to accept that there actually is a greater "emphasis" on sound, scientific nutrition and exercise amongst "CAM" practitioners, there is no documented evidence that they are any more successful than conventional practitioners in motivating their patients to make lifestyle changes.

The Report fails to point out that "CAM" "health promotion" and "prevention practices" also include preventing disease by "balancing qi", "eliminating parasites and toxins," "cleansing the liver" and/or by "cleansing the blood" via a multitude of supplements and questionable practices. Our uncritical acceptance of "CAM" wellness and health promotion can be interpreted as an endorsement of these claims. It is absolutely unclear what role, if any, "CAM" practices play in preventing disease and to what extent patients are burdened with useless treatments and products in their pursuit of "wellness".

The Contributions of Public Health and Medicine to Wellness

Registered dietitians, clinical nutritionists, conventionally trained scientists, physicians and public health professionals have done the bulk of the research in the area of nutrition. It is important not to overlook the contributions of the pioneering Framingham study that documented the epidemiology of obesity, smoking and heart disease, which led to heart healthy diets, smoking cessation,

and a greater emphasis on exercise. Through rigorous science we now have a much better understanding of the role foods, nutrients and exercise play in health and disease. The notion that only "CAM" supports healthy nutrition is neither accurate nor fair.

Furthermore, the suggestion that conventional medicine is primarily focused on disease, while "CAM" is primarily focused on health promotion and prevention was a point of contention on the Commission. This perspective fails to adequately acknowledge public health initiatives that have been an integral part of medicine for decades, efforts that have dramatically improved the health of the Nation.

Cooptation of Spirituality

The most troubling of these conflations is the inclusion of spirituality under the rubric of "CAM." There is no question that many Americans find comfort in prayer, religion and/or spiritual practices and that more attention should be paid to the role of spirituality in health care. Nonetheless, it is disconcerting that the Report often categorizes spirituality as a "CAM" modality. The Report cites papers that assert that when a patient is diagnosed with cancer and turns to prayer for comfort - he or she is considered to be using "CAM." When spirituality is so designated, "CAM" prevalence grows dramatically. The truth is that spirituality transcends any arbitrary designation of conventional and non-conventional medicine and cannot be claimed by any particular group. Furthermore, the conflation of spirituality and/or religion with CAM could lead to an abridgement of the free exercise of religion by subjugating its practice to a regulated modality.

In sum, generic pronouncements about "CAM" neither serve the public interest nor protect the public health. It is essential to separate the effective from the ineffective, the safe from the unsafe and to contextualize these practices against conventional modalities before any of them can be recommended for incorporation into the Nation's healthcare system. While recognizing that research will eventually answer many of these questions, the Commission's inability to distinguish and critically evaluate broad categories of practitioners and modalities in a meaningful way, limits the applicability of many worthy recommendations.

2.2 Public Preferences and the Regulation of Supplements

The access section of the Report is predicated upon the premise that, "The public has expressed interest in maintaining easy access to CAM practitioners." Notwithstanding the selection bias of those who presented public testimony to the Commission, the data does not support that this is the view of a majority of Americans. In fact, if we consider the regulation of dietary supplements as a well-studied case in point, the literature indicates that the use of dietary supplements

has decreased and that the majority of Americans support increased regulation of supplements, including requiring the Food and Drug Administration to review the safety of new dietary supplements prior to their sale.[vii] This support for increased regulation and safer products is likely a consequence of publicity surrounding St. John's Wort and drug-interactions, the potential liver toxicity of Kava,[viii] the presence of the anti-coagulant warfarin in PC-SPES, an herbal product used for prostate cancer[ix] and the presence of heavy metals in a number of Asian herbal preparations.[x] We strongly support a number of recommendations made in the Report regarding the quality, safety and advertising of dietary supplements and the full implementation of the Dietary Supplement Health and Education Act (DSHEA). However, it remains to be seen if the full implementation of DSHEA will provide the public with the right combination of access and safety that national surveys indicate it desires. For this reason, we strongly endorse the recommendation that Congress re-evaluate DSHEA following full implementation.

2.3 Vulnerable Populations

Patients will often resort to "CAM" practices, modalities and practitioners upon the diagnosis of a debilitating, chronic or terminal condition. Recent Senate hearings have documented the special vulnerability of the elderly on fixed-incomes to these phenomena.[xi] The Report's contention that medicine lacks adequate treatment for pain and symptom management could contribute to the mistaken notion that conventional medicine has nothing to offer patients who chronically ill or in the process of dying. It is important that the public be aware of the fine work done in hospices around the country and the emergence of palliative care as an important evidence-based clinical discipline able to ameliorate patient and family distress.

3. Closing Statement

We hope that the American public is well served by the Commission's work. The Commission made enormous progress during its deliberations and we support many of its recommendations. We believe that some of aspects of "CAM," when appropriately defined, have the potential to benefit the health of the American public. However, the Commission's inability to appropriately acknowledge the limitations of unproven and unvalidated "CAM" interventions or adequately address the minimization of risk necessitates this statement.

We remain optimistic that the work of the Commission and the many people who presented testimony before it will make a contribution to the public's understanding of this complex issue. We hope that the diversity of views on this topic does not engender divisiveness. Where medical care is concerned, the common good calls for ideology and advocacy to yield to scientifically sound evidence of safety and efficacy. We are confident that this can be accomplished

with respect and compassion for all Americans.

We appreciate the honor of serving with our fellow Commissioners and thank you for your consideration.
Respectfully Submitted,

Tieraona Low Dog, M.D. Joseph J. Fins, M.D., F.A.C.P.

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