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COMPLEMENTARY MEDICINE

A Report to the Legislature

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1998

January 15, 1998
Minnesota Department of Health
Health Economics Program



Correction

Complementary Medicine: A Report to the Legislature
Minnesota Department of Health
January 15, 1998

*Please note the following correction to Part III: Efficacy and Safety of CAM Therapies
Part D. Conclusion of the Minnesota Department of Health's Complementary Medicine Report.*

The recent journal, "The Scientific Review of Alternative Medicine" is *not* the first published peer reviewed journal for complementary and alternative medicine treatment. Other journals currently in print include the following:

Alternative Therapies in Clinical Practice
Complementary Therapies in Medicine: The Journal for All Health Care Professionals
The Journal of Alternative and Complementary Medicine:
 Research on Paradigm, Practice, and Policy
ADVANCES: The Journal of Mind-Body Health
Alternative Therapies in Health and Medicine

Concerns were raised by Advisory Committee members that the journal mentioned in the Department's report ("The Scientific Review of Alternative Medicine") was specifically created to discredit complementary and alternative treatments and may not be an objective source of research.

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Complementary Medicine

Final Report to the Legislature

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January, 1998

Dear Interested Party:

The study of complementary and alternative therapies is a very important and relevant issue in the current health care market. The growth of complementary and alternative medicine in America seems indisputable. In a landmark study published in the New England Journal of Medicine in 1993, Dr. David Eisenberg and his colleagues found that one in three patients in the United States regularly used complementary and alternative therapies.

As the legislature has indicated through mandating this report, it is important to begin to explore the potential implications of the increased use and acceptance of complementary and alternative medicine in Minnesota. The Minnesota Department of Health has an interest in assuring consumers' access to quality forms of health care. Our mission is to protect and promote the health and well-being of all Minnesotans.

The study we have completed is one step toward the goal of fully assessing and assuring that the health care delivery system meets the needs of the population. Our background exploration will lay the groundwork for further study and investigations of complementary and alternative medicine, as the issues involved are extremely complex. Although we do not expect that this project will provide definitive answers to all of the questions that have been raised, we do hope that the project will be a significant step toward better understanding these issues and providing a framework for further discussion and analysis.

Sincerely,

Anne M. Barry
Commissioner

Complementary Medicine

Table of Contents

Executive Summary and Recommendations	1
Part I. The Purpose of This Report	6
Part II. What is Complementary Medicine?	7
A. Definition of Complementary Medicine	7
B. Definitions of Some Component Terms in CAM	7
C. Categories of CAM Therapies	8
D. Additional Categories of CAM	11
E. Education and Training of CAM Providers	13
Part III. Efficacy and Safety of CAM Therapies	19
A. The Importance of Establishing a Research Base	19
B. The Present State of CAM Research	19
C. Challenges in Conducting Research of CAM	20
D. Conclusion	20
Part IV. Why Study CAM?	21
A. Growth and Development of the Importance of CAM in the U.S.	21
B. Why Is the Interest in CAM Rising?	21
C. Opponents of CAM	21
D. Worldwide View of CAM	22
Part V. Availability of CAM	23
A. Availability of CAM in the U.S.	23
B. Availability of CAM in Minnesota	24
Part VI. Utilization of CAM	27
A. Utilization in the U.S.	27
B. Reasons for Utilizing CAM	29
C. Utilization in Minnesota	30
D. Insurance Coverage in Minnesota	31
E. History of CAM in Minnesota	32
Part VII. Regulation of Complementary Medicine	34
A. The Purpose of Regulation of Health Professions	34
B. Types of Regulation of Health Professions	34
C. Medicine and Regulation	37
D. Regulation and CAM	37
E. Recent/Current Regulations of CAM Nationwide	40
F. Licensing Health Professions in Minnesota	40
G. Existing Regulation of CAM Therapies in Minnesota	44
H. Implications of Regulation	47

I. Interplay of Regulatory and Economic Variables	48
J. Occupational Regulation and Health Care Reform	50
K. Issues Involved in Considering Regulation	51
Part VIII. Summary and Conclusion	53
Bibliography	54
Appendix A Health and Human Service Appropriations, S.F. 1908, Article 1.	66
Appendix B Complementary Medicine Study Advisory Committee Members	68
Appendix C CAM Therapies: A Partial Alphabetical Listing	70
Appendix D Regulation of CAM in Other States	80
Appendix E Examples of Insurance Coverage of CAM	102

EXECUTIVE SUMMARY

In 1997, the Minnesota Legislature directed the Department of Health to conduct a study based on existing literature, information, and data on the scope of complementary medicine in Minnesota (See Appendix A for a copy of the legislation). This study was to include information on the types of complementary medicine therapies available in the state, information on existing regulation of complementary medicine, utilization, and the extent of health plan coverage of complementary medicine therapies. The study was also to include recommendations on possible regulation of one or more complementary medicine provider groups. The legislature also directed the Commissioner of Health to convene a Complementary Medicine Advisory Committee. The committee includes representation from health care providers, including providers of complementary care, consumers, and health plans. This advisory committee was convened in September 1997 and provided input and advice on the development of this report. (See Appendix B for the membership of the Complementary Medicine Advisory Committee.)

This report provides background information on complementary medicine, describes the therapies involved, and outlines the issues related to coverage, regulation, service delivery and outcomes of care. The report outlines regulatory approaches, and makes recommendations on some general principles of regulation of complementary medicine providers. Because of the short time frame and the complexity of the issues involved there remains a significant amount of work to be done. The following recommendations outline future tasks that should be addressed in further study of complementary and alternative medicine. This Executive Summary outlines the guiding principles discussed by the Complementary and Alternative Medicine (CAM) Advisory Committee and a list of recommendations forwarded by the Commissioner of Health. The report which follows provides more in depth definitions and additional discussion of the issues.

Guiding Principles: Regulation of Complementary and Alternative Medicine

- Alternative/complementary forms of health services and therapy are present and widely used by consumers in Minnesota.*
- The legislative policy objective of state occupational regulation is the protection of consumers.
- Creative alternatives to regulatory approaches should be sought where possible.
- Regulation should not inhibit innovation in the health care market and the development of alternative approaches to health care, except when necessary to protect the consumer.
- Consumers should have the broadest market access possible to complementary, cultural, and alternative health care practitioners, as long as safety is assured. Regulation should interfere as little as possible with the availability to

consumers of the wide variety of complementary, alternative and allopathic providers.

- If regulation is necessary, the least restrictive form of regulation should be used.
- Where regulation is necessary, it should adopt the most suitable standards that assure a high quality of care for consumers. At the same time, regulation should not unnecessarily restrict the practice of any individual where there is no risk to the public safety.
- Regulation of a practice is needed if there is demonstrated evidence of risk to public safety.
- There is a need for legislation to allow licensed and unlicensed providers of complementary medicine to practice without fear of criminal or administrative prosecution from existing regulatory authorities solely based on the provision of complementary or alternative medicine.

**Based on national data that one in three patients in the United States regularly used complementary and alternative medicine in 1993. (Eisenberg, 1993)*

Recommendations and Future Activities

I. Continued Work on the Complementary Medicine Study

- The Minnesota Department of Health should continue to study the issue of complementary and alternative medicine in Minnesota with the continued advice and input of the CAM Advisory Committee.
- The advisory committee membership should be expanded to reflect the major cultural traditions present in Minnesota and from which many of the techniques of complementary and alternative medicine originate.
- The advisory committee membership should also be expanded to include more representation from public and private payers.
- Staff and funding should be provided to guide and carry out future research. Future research topics should include:
 - The advisory committee should continue to study regulation of specific occupational groups.
 - Cost comparison of allopathic and complementary and alternative treatments, potential cost savings to the health care system, and payment issues, including study of alternatives to encourage third-party coverage of complementary and alternative medicine.

--A survey on use and prevalence of complementary and alternative medicine in Minnesota should be conducted only when specific information is needed to guide policy development.

--With assistance from the attorney general's office, the Minnesota Department of Health, and other existing regulatory authorities, the committee should research the effectiveness and appropriateness of the following options for regulation:

- Creating a new act to assure provider freedom of practice;
- Examine existing licensure acts and review or amend them in order to clarify scope of practice boundaries and jurisdiction; and
- Create a complaint, investigative, and enforcement system for complementary and alternative medicine providers and consumers similar to the scheme for unlicensed mental health providers.

The Legislature will benefit from this research by being provided the necessary information to make long-term decisions about complementary and alternative therapy in the state of Minnesota.

II. Chapter 214

- Chapter 214, which establishes policies for occupational regulation, should be evaluated and affirmed or amended by the Legislature in light of changes in the health market, promotion of consumer choice and responsibility in health care decisions, and health care reform initiatives which focus on health care system cost, quality and access.
- The underlying tenant of Chapter 214 should be retained. That is: *"The legislature declares that no regulation shall be imposed upon any occupation unless required for the safety and well-being of the citizens of the state."*

III. Provider Freedom of Practice

- Freedom of practice legislation, which allows providers to continue providing services as long as the service is not shown to be dangerous or harmful, should be considered as a possible alternative to licensure or registration. This may require making some changes in the Medical Practices Act or other licensure laws of health practice acts.
- Prosecution for complementary and alternative medicine should be restricted to those cases documenting harm to patients.
- Complementary and alternative medicine providers, otherwise licensed or not, should be subject to the jurisdiction of an appropriate licensing board or a newly created unlicensed complementary and alternative medicine provider act.

IV. Minimum Requirements for Formal Regulation Systems

- Prerequisites of any new regulatory structure, such as licensure or registration should be that the health occupation has the following:
 - existing, accepted standards of education and training for competent practice;
 - a national psychometrically valid and reliable test for measuring achievement of minimum or entry-level skill and knowledge; and
 - sufficient practitioners such that reasonable fees are paid to support the cost of state regulation.
- Licensure should not be recommended unless there is actual or great potential for mental or physical harm that is serious, immediate and irreparable, the harm arises from incompetent performance of an occupational activity, and the incompetence is caused by a lack of training or education.

V. Occupational Regulatory Reform

- Recommendations for regulation of complementary and alternative medicine should be integrated with national concerns and reform activities related to the regulation of health professionals in general (PEW Commission Report) and the activities of the Minnesota Legislature's Joint Senate Subcommittee on Occupational Licensure.

VI. Interim Steps Required for Consumer Protection

- Alternatives should be immediately available which address consumer protection and quality concerns. Alternatives could include the following:
 - Complaint, investigative, and enforcement processes for unlicensed providers similar to that provided for unlicensed mental health providers. The authority could be given, for example, to the Minnesota Department of Health, the Board of Medical Practice, or the Attorney General. The process should focus on harm arising from unethical/unprofessional conduct. Competency standards should *not* be established at this time.
 - Requirements for unlicensed providers to obtain informed consent or appropriate waivers from consumers.
- Consumer and health care practitioner outreach and education should be provided so that consumers are informed of responsibilities and risks concerning what is available, how it is regulated, and how complaints can be made. This could be done either through public or private mechanisms or a combination of the two.

VII. Recommendation Concerning Specific Complementary and Alternative Medicine Occupations

The Complementary Medicine Committee did not have sufficient information or time to reach consensus on recommendations concerning the licensure initiatives by naturopathic and massage representatives. The complementary medicine committee recommends that the issues regarding these licensure initiatives be discussed as part of the continued work of the complementary medicine study.

PART I: THE PURPOSE OF THIS REPORT

In 1997, the Minnesota Legislature directed the Department of Health to conduct a study based on existing literature, information, and data on the scope of complementary medicine in Minnesota (See Appendix A for a copy of the legislation.) This study was to include information on the types of complementary medicine therapies available in the state, information on existing regulation of complementary medicine, utilization, and the extent of health plan coverage of complementary medicine therapies. The study was also to include recommendations on possible regulation of one or more complementary medicine provider groups. The legislature also directed the Commissioner of Health to convene a Complementary Medicine Advisory Committee. The committee includes representation from health care providers, including providers of complementary care, consumers, and health plans. This advisory committee was convened in September, 1997 and provided input and advice on the development of this report. (See Appendix B for the membership of the Complementary Medicine Advisory Committee.)

This report provides background information on complementary medicine, describes the therapies involved, and outlines issues related to coverage, regulation, service delivery, and outcomes of care. The report also outlines regulatory approaches, and makes recommendations on some general principles of regulation of complementary medicine providers. Because of the short time frame and the complexity of the issues involved there remains a significant amount of work to be done. The recommendations outline some future tasks that should be addressed further study on complementary and alternative medicine.

PART II: WHAT IS COMPLEMENTARY MEDICINE

A. Definition of Complementary Medicine

The term 'complementary medicine' covers a broad range of healing philosophies, approaches and therapies. Other terms used to refer to this wide variety of health care methods include alternative medicine, holistic medicine, cultural healing practices, natural health care, integrative medicine, unconventional medicine, and unorthodox medicine. These therapies are hard to define because they encompass a broad spectrum of practices and beliefs. From a sociological point of view, unconventional therapies refer to medical practices that are not in conformity with the standards of the medical community. (Eisenberg, 1993)

In 1991, the National Institutes of Health established the Office of Alternative Medicine (OAM) and the Office of Dietary Supplements to promote and guide high quality research and disseminate information on Complementary and Alternative Medicine to clinicians, researchers, and consumers.

The OAM established the "Panel on Definition and Description of Alternative Medicine" at the Complementary and Alternative Medicine Research Methodology Conference. According to the panel, in the United States CAM refers to the broad domain of all health care resources to which people have access other than those intrinsic to biomedicine. The panel proposed the following definition of the field of complementary and alternative medicine:

"Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed." (OAM, 1997)

For the purposes of this report, we will use the term *Complementary/Alternative Medicine (CAM)*, as defined above, for the wide range of complementary or alternative therapies discussed in this report. When discussing biomedicine therapies that are considered the "medical mainstream," we will use the term *allopathic medicine*.

B. Definitions of Some Component Terms in CAM

Complementary medicine is a term which emphasizes the joint use of allopathic and alternative therapies. (Gordon, 1996) The term, "complementary" is different from "alternative" because it implies the use of modalities together with, or as a complement to, the offerings of allopathic medicine. (OAM, 1997)

Alternative has been used to suggest substitution. Sometimes this either-or relationship implies that alternative modalities are used in place of conventional medicine. (OAM, 1997) *Paradigm Shift* reflects a philosophical shift in the definition of healing. This term recognizes that the relationship between the healer and the patient is a partnership. The provider is a teacher and a guide, instead of an authority figure giving instructions to the patient. This shift in paradigm also reflects an understanding that the body has a natural capacity for self-healing.

Holistic is derived from the Greek word meaning whole. The word holism was coined in 1926 and was revived in the 1970s to denote an approach that addresses the uniqueness of individuals, seeks to understand whole people in their total environments, and employs a wide range of allopathic and CAM therapies. (Gordon, 1996)

C. Categories of CAM Therapies

It is difficult to categorize the types of CAM therapies because many of them share a common philosophy. The distinctions can be somewhat nebulous and difficult to define.

One approach to categorizing CAM focuses on the scientific status of the therapies. Dr. Timothy Gorski, for example, organizes CAM therapies into three categories, including:

- 1) treatments that are not accepted by the medical mainstream because they are still subject to investigation regarding efficacy and cost;
- 2) therapies that are “outside the medical mainstream” because they reflect personal, religious, or cultural preferences; and
- 3) “disproven or unproven practices” that contradict medical science or common sense, and may be dangerous. (Berlin, 1997)

A second approach to categorizing medicine focuses on the degree of invasiveness of the therapy, and arranges therapies (CAM as well as allopathic medicine therapies) along a continuum ranging from the least invasive (such as prayer therapy) to the most invasive (such as surgery). (NIH, 1992)

The Report to the National Institute of Health (NIH) on Alternative Medical Systems and Practices in the United States, called “Alternative Medicine: Expanding Medical Horizons,” arranges the CAM therapies into seven fields, based on the nature and scope of the therapy. The seven fields, according to the NIH, are:

- 1) Alternative Systems of Medical Practice;
- 2) Mind-Body Interventions;
- 3) Manual Healing Methods;
- 4) Pharmacological and Biological Treatments;
- 5) Herbal Medicine;
- 6) Diet and Nutrition; and
- 7) Bioelectromagnetics Applications in Medicine.

Below, using the system of organization defined by the NIH, is a brief description of these seven fields of CAM. Included in the description are examples of the types of therapies under each heading.

For a description of some of the specific therapies referenced in this section, please see the alphabetical listing in Appendix C.

1. Alternative Systems of Medical Practice

The NIH report discusses alternative systems of medical practice based on the type of health care delivered, including *Professionalized Health Systems* and *Community Based Health Care Practices*.

a. Professionalized Health Systems. Practitioners within a professionalized health system undergo standardized training. Major professionalized systems have certain characteristics, including: a theory of health and disease; an educational scheme to teach its concepts; a delivery system involving practitioners; a material support system to produce medicines and therapeutic devices; cultural expectations about the medical system's role; and a means to confer professional status on approved providers. Examples of professionalized medical systems include:

- Acupuncture;
- Anthroposophically extended medicine;
- Ayurvedic medicine;
- Chiropractic;
- Environmental medicine;
- Homeopathy;
- Naturopathic Medicine; and
- Traditional Oriental Medicine

b. Community-based Health Care Practices. The NIH Report defines community-based health care as forms of healing offered within various cultures that are not professionally formalized. Examples of community-based health care are shamans, medicine-men/women, and traditional midwives. (NIH, 1992)

2. Mind/ Body Interventions

The mind-body interventions are based on a belief in the profound interconnectedness of mind and body. According to this modality, social, economic, and familial factors affect and modify all aspects of individual health and illness. Examples of mind-body interventions include: Art Therapy, Biofeedback, Counseling, Dance Therapy, Guided Imagery, Humor Therapy, Hypnotherapy, Meditation, Music Therapy, Prayer Therapy, Psychotherapy, Relaxation Therapy, Support Groups, and Yoga. (NIH, 1992)

3. Manual Healing Methods

The manual healing methods are based on the understanding that dysfunction of one part of the body often affects other discrete body parts. Consequently, theories and processes have been developed for correcting secondary dysfunctions by manipulating soft tissues or realigning body parts. According to this method, overcoming misalignments and manipulating

soft tissues bring the parts back to optimal function, and the body returns to health. The manual healing methods discussed in the NIH report on alternative medicine may be classified as follows:

- Physical Healing Methods (Osteopathic Medicine, Massage Therapy)
- Pressure Point Therapies (Reflexology, Acupressure Systems, Traditional Chinese Massage)
- Postural Re-education Therapies (Alexander Technique, Feldenkrais, Trager, Rolfing)
- Biofield Therapeutics
- Combined Physical and Biofield Methods (Polarity Therapy, Network Chiropractic Spinal Analysis) (NIH, 1992)

4. Pharmacological and Biological Treatments

The pharmacologic and biologic treatments use certain substances in the same way that modern pharmaceuticals are used. However, these substances are not recognized by allopathic medicine. (NIH, 1992)

Examples of biological and pharmacological treatments currently being offered by alternative medical practitioners include:

- Cartilage products derived from cattle, sheep, sharks, and chickens, which are being used to treat cancer and arthritis; and
- Ethylene diamine tetraacetic acid (EDTA) chelation therapy, used to treat heart disease, circulatory problems, rheumatoid arthritis, and to prevent cancer. Chelation therapy involves removal of divalent metals, e.g. lead, calcium, etc., from the circulating blood by intravenous infusion of EDTA that forms a metal-complex chelate which is then excreted via the urine. (Kaul, 1996)

5. Herbal Medicine

Herbs are used in a variety of different ways, including pills, tinctures, ointments, lozenges, gels, and creams. Herbs may have been the first human healing system, and they are an important aspect of indigenous healing practices throughout the world. Many drugs commonly used today are of herbal origin. About one-quarter of the prescription drugs dispensed by community pharmacies in the United States contain at least one active ingredient derived from plant material. (NIH, 1992)

The American Herbalists Guild was formed in 1989 to address specific concerns for professional herbal practitioners. The main purpose of the Guild at present is to develop a professional body that promotes and maintains standards in herbal practice. It does this through advancing educational standards and the use of a peer review for professional applicants. Because of the great diversity of traditions and practices in herbal medicine, the Guild established standards based upon peer-review, rather than testing. Instead of simply passing a standardized test, the applicant for professional status takes a test which is reviewed by a committee of his or her peers—practicing herbalists. There are at present 88 professional members and over 350 student members of the American Herbalists Guild. (Wood, 1997)

The World Health Organization estimates that 4 billion people, 80 percent of the world population, presently use herbal medicine for some aspect of primary health care. Herbal medicine is a major component in all indigenous peoples' traditional medicine and a common element in Ayurvedic, homeopathic, naturopathic, traditional oriental, and Native American Indian medicine. (NIH, 1992)

6. Diet and Nutrition

Alternative dietary approaches are based on a conviction that food should be our medicine and medicine should be our food. This approach finds that pollution, pesticides, herbicides and modern methods of food preparation degrade the food supply and are responsible for a plethora of chronic illnesses. Dietary strategies may address either illness prevention or the cure of a disease. These approaches may be directed at a single disease, or they may become a way of life. (NIH, 1992)

7. Bioelectromagnetic Applications in Medicine

Bioelectromagnetics uses electromagnetic fields as a form of healing. Electrical phenomena are found in all living organisms, and electrical currents in the body can produce magnetic fields that extend outside the body. These fields from the body can be influenced by external magnetic and electromagnetic fields. Changes in the body's natural fields may produce physical and behavioral changes. This category of CAM systems include the following modalities: BlueLight Treatment and Artificial Lighting, Electroacupuncture, Electromagnetic Fields, Electrostimulation and Neuromagnetic Stimulation Devices, and Magneto-Resonance Spectroscopy. Major new applications of nonthermal, nonionizing electromagnetic fields include: bone repair, nerve stimulation, wound healing, treatment of osteoarthritis, electroacupuncture, tissue regeneration, and immune system stimulation. (NIH, 1992)

D. Additional Categories of CAM

The Complementary Medicine Advisory Committee agreed that it is important to expand the categories established by the NIH. Additional categories developed by the complementary medicine advisory committee include Cultural Health Practices and Midwifery.

1. Cultural Health Practices¹

Cultural health practices emphasize the presence of many different cultures from all across the globe living together in a contemporary world. Cultural health practices seek to affirm unique cultural practices and create a space for sharing community and health within an individualistic and fast-paced society. Cultural health affirms each culture as knowledgeable, resourceful, effective, important, and valuable on its own. Members of each unique culture are enlivened and empowered by the dialogue they share with others in their community, as well as other cultures.

¹The following information was taken from a personal interview with Michele Strachan, Medical Director, and Ahmad Azzahir, Phillips/Powderhorn Cultural Wellness and Health Education Center.

Cultural health practices find each person to be a reflection and an extension of his or her place within the universe, the environment, the community, and the family. According to cultural health practices, disease expresses itself at all levels, including physical, emotional, mental, and spiritual. Thus, healing should occur at all levels. Many tools and techniques are used in cultural health practices, such as herbs, roots, barks, symbols, stories, rituals, chanting, movement, drumming, music, bodywork, and manipulation of the body and the environment.

Examples of cultural health practices are the Hmong shaman, the African shaman or herbalist, the traditional Chinese healer or herbalist, the Ojibwe, Lakota or Potwatoni medicine men/women, the traditional midwife in many cultures, and the Chicano/Latino curandero/a.

The Powderhorn/Phillips Cultural Wellness and Health Education Center in South Minneapolis, Minnesota is one place committed to creating, building, and nurturing a space for cultural health practices. Through a program called "Healthy Powderhorn" supported by the Allina Foundation, the wellness center hosted over 1,000 meetings within the communities in South Minneapolis to discuss the "people's theory" of what contributes to sickness or health. The focused sessions with people from many different age groups within many cultures led to an agreed-upon understanding that illness and disease result from individualism, isolation, and a loss of belonging to a culture and community. The people involved in the discussions identified that wellness and good health are attained by pursuing personal spirituality, healthy relationships with family, elders, and children, and identifying with one's own community and heritage.

The wellness center offers classes that focus on three areas:

- 1) Reconnection to Heritage;
- 2) Educated Lifestyle Practice, which includes instruction in diet and nutrition and exercise; and
- 3) Restoring and Maintaining Harmony, which builds skills and offers support in healthy community building and personal kinship networks.

Cultural health practices affirm that stories and anecdotes are a legitimate way of expressing knowledge. Sharing meaningful symbols and stories creates a harmony that contributes to individual and community wellness.

Generally, cultural healing is practiced "underground" and is not affirmed or recognized by the dominant, allopathic form of medicine. Those who practice cultural healing believe that allopathic medicine and cultural healing cannot be measured by the same modern science because they are each grounded in a different epistemology of what contributes to illness, health, and well-being.

2. Traditional Midwifery²

Traditional midwifery seeks to provide women's health services from a natural and non-medical perspective. Midwives have been an integral part of women's health services from the beginning of recorded history. Today, traditional midwifery still exists as the basis for maternity services in almost every nation, with seventy-five percent of Western European births attended principally by midwives. The World Health Organization's statement on midwifery is that, "the curricula for the education of all health professionals should reflect the role of the midwife as the primary care giver in maternity care." (Granju, 1997)

Traditional midwives are educated in normal pregnancy, childbirth, and postpartum care. They devote considerable time to educating mothers and families during prenatal care and preparing them for birth, breast feeding, and newborn care. Traditional midwives strive to meet the physical, emotional, and spiritual needs of each woman and family.

In order to integrate traditional midwifery with contemporary health practices, the Midwives Alliance of North America has helped create a competence-based certification process, called the "NARM Certified Professional Midwife." This certification process allows some traditional midwives to practice in a professional capacity.

The goals of the international traditional midwifery movement is to validate and preserve ancient, as well as modern, routes to traditional midwifery practice, and to be accessible for all consumers choosing this unique form of family-centered care. Traditional midwives offer a preventative, holistic model of care that recognizes the importance of parental responsibility and choice within the birthing process. Today, there are an estimated 20 to 40 traditional midwives providing maternity care in Minnesota.

E. Education and Training of CAM Providers

CAM practitioners have a very diverse educational background. Training in some of the therapies may be obtained from several different sources, such as: formal education in an accredited institution of a required duration, correspondence courses, apprenticeships, learning from community/family members, self-learning, institutions that specialize in teaching a particular type of therapy of varying duration, short courses, seminars, conferences, and workshops.

Alternative therapies are gaining interest in medical school curricula. As of 1996, 34 medical schools in the United States, including Harvard, Yale, and Johns Hopkins, are offering courses in alternative medicine. (Kennedy, 1997) In 1997 the University of Minnesota Academic Health Center recently created the Center for Spirituality and Healing. The goal of the center is to serve Minnesota and the nation through research and development of innovative, interdisciplinary models of education and patient care. The Center seeks to reflect integration of conventional, complementary, spiritual, and culturally appropriate approaches to healing. (Read, 1997)

²This section based on personal correspondence with James Van Horn, who gathered information from conversations with traditional midwives and various articles from the "Minnesota Midwives Guild" and "Midwives Alliance"

Many nursing schools, such as Bethel College in Colorado Springs, Colorado, the University of Texas, and Jefferson Medical College in Philadelphia provide holistic care training. (American Holistic Nurses Association, 1997) Below are several examples of modalities that provide formal schooling for their providers.

1. Chiropractic³

The Council on Chiropractic Education (CCE) originated in 1935 to ensure the quality of chiropractic education in the United States by means of:

- accreditation, certifying the quality and integrity of programs or institutions;
- educational improvement, stimulating educational excellence within programs or institutions; and
- public information, informing the educational community and the public of the nature, quality, and integrity of chiropractic education.

In 1974, the U.S. Office of Education approved the CCE as the recognized agency for accreditation of chiropractic education. Since then, the CCE has grown from four programs and institutions with 1,300 students to sixteen programs and institutions serving more than 14,000 students in 1995. The following is a list of CCE accredited programs and institutions in the United States:

- Cleveland Chiropractic College, Kansas City, MO
- Cleveland Chiropractic College, Los Angeles, CA
- Life College, Marietta, GA
- Life College West, San Lorenzo, CA
- Logan College of Chiropractic, Chesterfield, MO
- Los Angeles College of Chiropractic, Whittier, CA
- National College of Chiropractic, Lombard, IL
- New York College of Chiropractic, Seneca Falls, NY
- Northwestern College of Chiropractic, Bloomington, MN
- Palmer College of Chiropractic, Davenport, IA
- Palmer College of Chiropractic West, San Jose, CA
- Parker College of Chiropractic, Dallas, TX
- Sherman College of Straight Chiropractic, Spartanburg, SC
- Texas Chiropractic College, Pasedena, TX
- University of Bridgeport College of Chiropractic, Bridgeport, CT
- Western States Chiropractic College, Portland, OR

³This section is based on a summary of chiropractic education provided by the Minnesota Chiropractic Association.

The minimum requirements as set forth by CCE for admission to a chiropractic college or program are the following:

1. Applicants must have completed two academic years (60 semester hours or 90 quarter hours) of college credit (100 level or above) acceptable toward a baccalaureate degree (see required distribution). Pre-chiropractic courses must be completed at a regionally accredited institution recognized by the United States Office of Education.
2. Specific course requirements include biology, zoology, general or inorganic chemistry, organic chemistry, physics, psychology, English/communication, and humanities/social sciences.
3. Applicants should have earned a cumulative GPA of at least 2.5 and a science GPA of at least 2.0.

Chiropractic curriculum consists of four to five academic years, depending on whether the institution or program is based on semesters or trimesters. The curriculum is made up of courses in basis science, chiropractic science, clinical science and clinic experience. The course of required study includes anatomy, embryology, biochemistry, gynecology, physiology, microbiology, histology, otolaryngology, pathology, diagnostic imaging procedures, psychology, biomechanics, orthopedics, first aid and emergency procedures, infectious diseases, cardiology, gastrointestinal, geriatrics, endocrinology, obstetrics, dermatology, principles and practice of chiropractic, research methods and procedures, pediatrics, public health, physiotherapy, nutrition, physical, clinical and laboratory diagnosis, and professional practice ethics. A 12 month public internship and preceptorship are required for graduation. The required curriculum for the Doctor of Chiropractic degree is composed of a sequence of course totaling 4,380 contact hours, exclusive of electives.⁴

Chiropractic colleges are established around the world with colleges in England, Canada, Australia, and South Africa, and emerging colleges in Brazil and Mexico.

2. Traditional Oriental Medicine

Traditional oriental medicine is a newer discipline in the United States. It includes the practice of acupuncture, Chinese herbs, and related therapies following the principles of traditional Chinese medicine. A national board certification examination is given by the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), and this certification is required by most of the states that license acupuncturists. There are approximately 60 schools and colleges offering full oriental medical and acupuncture programs at present. Thirty-three are members of the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM). Accreditation is through the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM). Twenty-four colleges have achieved accreditation, ten are in candidacy status, and twelve more have applied for

⁴This curriculum is the curriculum of Northwestern College of Chiropractic. While there may be some variances from one institution or program to another, the CCE requires the same courses for the Doctor of Chiropractic degree.

candidacy. This adds up to 47 schools on the accreditation track and 14 schools are not so engaged. The most recent data (1997) from the ACAOM reports that there are estimated 5,000 students presently enrolled in acupuncture or oriental medical schools. In 1995, 866 graduates of CCAOM schools were reported. Entry-level education for the profession is at the Master's level, with two years of post-secondary academic education as a prerequisite for admission to an accredited school. Minimum program length is three years with at least 1800 hours for professional acupuncture degrees or diplomas, and four years with at least 2400 hours for oriental medical graduates. (The Acupuncture program does not include herbal studies.) The largest number of schools are in California, with clusters in Texas and Florida, and a few up the Atlantic coast. There are two in the upper Midwest and a few in Colorado. Minnesota has one school, the Minnesota Institute of Acupuncture and Herbal Studies, which opened in 1990, and is now a candidate for accreditation. (Davis, 1997)

3. Naturopathy

Practitioners of this modality are currently in debate about training requirements for entry to the profession. This disagreement is articulated by two different associations: The American Association of Naturopathic Physicians (AANP), which represents providers of "naturopathic medicine;" and The Coalition for Natural Health, a national group of "traditional naturopaths." Education requirements for the forms of naturopathy are described below.

a. Naturopathic Medicine. The AANP states that the profession of naturopathic medicine is based on accredited educational institutions, professional licensing by individual states, national standards of practice and care, peer review, and scientific research. According to the AANP, naturopathic physicians (NDs) receive extensive academic training and use therapies that are primarily natural and nontoxic, including clinical nutrition, homeopathy, botanical medicine, hydrotherapy, physical medicine, and counseling. The AANP states that NDs use the same methods of clinical, physical, and laboratory diagnosis as allopathic providers. In addition, NDs also spend time looking for contributing factors in patients' lifestyle, habits, attitudes, or constitution. According to the AANP, NDs are the only primary care medical professionals in the United States that exceed the 1988 recommendations of the U.S. Surgeon General for medical education in nutrition and dietary counseling.

Naturopathic physicians are trained in four-year naturopathic medical college programs. The Council on Naturopathic Medical Education is recognized by the U.S. Secretary of Education as the national accrediting agency for programs leading to the Doctor of Naturopathy and Doctor of Naturopathic Medicine degrees. The Council considers four-year, in-residence, graduate level colleges and programs for accreditation. Eleven state naturopathic licensing boards currently require graduation from a four-year naturopathic medical college for licensing. There are currently four colleges of naturopathic medicine in the United States. These colleges were founded in 1956, 1978, 1992, and 1997, respectively. Two are fully accredited by the Council on Naturopathic Medical Education. The other two schools have been accepted as candidates for accreditation.

b. Traditional Naturopathy. The Coalition for Natural Health states that traditional naturopathy avoids invasive procedures, such as drugs, pharmaceuticals, and surgery in order to "do no harm." According to the Coalition of Natural Health, traditional naturopaths promote self-healing and prevention through education, counseling, and using natural

substances, such as foods, vitamins, minerals, air, water, heat, cold, sound, and light. Traditional naturopaths receive training from a variety of sources such as: correspondence courses, apprenticeships, studying with community/family members, self-learning, institutions that specialize in teaching a particular type of therapy of varying duration, short courses, seminars, chiropractic schools, or schools that do not mandate clinical training.

According to the Coalition for Natural Health, traditional naturopaths are practicing education, instead of medicine. They do not diagnose illness, perform surgery, or prescribe prescription medications. Traditional naturopaths recognize that a state of good health will be established and healing will occur naturally in the human body if it is given a proper diet, pure water, fresh air, sunlight, exercise, and rest. The Coalition for Natural Health states that traditional naturopaths educate their clients for a healthy, strong, and independent future.

c. Homeopathy. The Council on Homeopathic Education (CHE) was formed in 1982 to monitor and approve the quality of courses offered for professionals. Two naturopathic medical colleges, Bastyr University in Seattle, Washington and National College of Naturopathic Medicine in Portland, Oregon, which offer four-year programs leading to an ND degree, also provide basic training in homeopathy, and are approved by the Council on Homeopathic Education. (National Center for Homeopathy, 1997)

Homeopathic programs include the following: The National Center for Homeopathy runs a basic 2-week introductory course each summer. Advanced training is available through the Hahnemann College of Homeopathy in Albany, CA (864 hours in 9 four-day sessions per year for 4 years), the International Foundation for Homeopathy in Seattle (240 hours in 10 four-day sessions), the Canadian Academy of Homeopathy in Toronto (728 hours), and Northwestern School of Homeopathy in Minneapolis (1058 hours in 36 4-day sessions). All these are approved by the CHE. Other programs offered around the country include several part-time programs that offer 200 hours or more of training in homeopathic methodology, and two colleges in the U.K. which have made home-study courses available in the U.S. (National Center for Homeopathy, 1997)

Non-Professional Homeopathic Training: For consumers that seek to learn how to use homeopathy for themselves, their families, and their animals, the National Center for Homeopathy (NCH) has 10 courses to choose from at its summer school. Study groups may also be a source of training in homeopathy. The NCH directory of Practitioners, Study Groups and Resources contains a listing of the study groups by location. The annual NCH conference also offers workshops and seminars for consumers as well as professionals. Any programs designed for licensed health care professionals are also open to non-professionals. (National Center for Homeopathy, 1997)

Homeopathy is practiced by many licensed health care professionals, including doctors, dentists, nurses, chiropractors, and veterinarians. There are also many professional homeopaths who do not have a separate health care license. The Council for Homeopathic Certification sets minimum standards for certification as 500 hours of formal homeopathic training, plus one year of experience, and an exam.

The North American Society of Homeopaths has identical requirements. This certification is offered to licensed and unlicensed homeopaths. (Johnson, 1997)

In Minnesota, *Northwestern School of Homeopathy* in Plymouth offers a 36-month program which follows the 1993 guidelines published by the International Council on Homeopathy. This school incorporates philosophy classes with 500 hours of clinical training and patient cases.

PART III: EFFICACY AND SAFETY OF CAM THERAPIES

A. The Importance of Establishing a Research Base

According to a widely-cited study on complementary and alternative medicine, one-third of all Americans used at least one form of CAM in 1990. (Eisenberg, 1993) Because there is new and growing demand for CAM therapies, consumers, providers, and third party payers are anxious to know which modalities are safe and effective. As allocation decisions regarding health care are made, it is also critical to have evidence upon which to base those decisions. In the interest of ensuring quality health care choices for the public, medical and legal guidelines must be established based upon sound and validated research evidence.

Under the current system of science, in order for a study to establish effectiveness or safety, the research must be conducted under certain rigorous requirements. A study is considered to be methodologically sound if it is "double-blind" (meaning that both the doctor and the patient do not know whether the patient is receiving the treatment or the placebo), has a well-defined outcome, has a large number of patients involved in the study, and patients receiving the treatment or the placebo are randomly selected. (Kleijnen, 1991)

B. The Present State of CAM Research

The field of CAM is very broad and diverse and includes many systems of care. In 1991, the National Institutes of Health established the Office of Alternative Medicine to promote and guide high quality research and disseminate information on CAM to clinicians, researchers, and consumers. A summary of the research base for CAM treatments published by the NIH in 1992 describes the types of research undergone up until the time it was printed. More and more studies on the efficacy and safety of various types of CAM therapies are emerging. Research is being conducted by state and local governments, individual foundations, medical schools, and CAM research centers.

One example of a state government study is a report on the costs, benefits, and risks associated with the use of CAM submitted to the Maryland Governor by the Maryland State Commission on Complementary Medical Methods. The commission found some CAM therapies to be safer and more effective than allopathic treatments for osteo-arthritis, disk disease, elevated cholesterol, carpal tunnel syndrome, and benign prostatic hypertrophy. (Department of Health and Mental Hygiene, 1995)

In addition, many of the schools of alternative medicine conduct research. Most of the 16 chiropractic colleges, and all of the osteopathic medical colleges have research facilities. Other institutions with research abilities in the United States include, Bastyr University in Seattle, National College of Naturopathic Medicine in Portland, OR, Southwest College of Naturopathic Medicine and Health Sciences in Scottsdale, AZ, and the Traditional Acupuncture Institute in Columbia, MD. (NIH, 1992)

NIH funding has generally not been available for these institutions. As a result, research facilities at such institutions have had limited development of infrastructure and faculty. Communication between these research facilities and allopathic research institutions is also minimal. (NIH, 1992)

C. Challenges in Conducting Research of CAM

Even though CAM efficacy studies have been conducted, many therapies have not undergone adequate research and peer review. The NIH report has identified several issues unique to CAM therapies which present barriers to conducting safety and efficacy studies.

In general, CAM research is lacking adequate funding. Because of limited financial resources, there are very few research facilities and no centrally located research database dedicated to CAM. (NIH, 1992)

In addition to limited resources, researchers have found difficulties in developing appropriate research methods for CAM. The difficulties arise because CAM practitioners and biomedicine practitioners do not always share the same understanding of what causes health or disease. CAM practitioners generally operate using the terms "energy," "holism," and "harmony," which cannot be measured under biomedical research methods. As a result, few researchers are adequately trained to develop studies or interpret the outcomes of CAM research studies. (NIH, 1992)

D. Conclusion

In October 1997, the first published peer review forum for CAM therapies will be launched. The new journal, called "The Scientific Review of Alternative Medicine," will publish original research, provide critiques of published work and review and discuss evidence for various treatments and the principles of researching alternative medicine. Journals such as the Scientific Review of Alternative Medicine contribute to the validity and acceptance of some forms of CAM therapy. As emerging peer-reviewed published research becomes more readily available, certain CAM therapies will most likely become more visible, available, and widely used.

PART IV: WHY STUDY CAM?

A. Growth and Development of the Importance of CAM in the U.S.

The importance of CAM in this country is evident from the number of people who are using it. (Eisenberg, 1993) In New Jersey, for example, a number of institutions have begun to integrate CAM into their array of services. The Kessler Institute for Rehabilitation has created the Center for Research in Complementary and Alternative medicine to look at the impact of a variety of therapies on physical rehabilitation. UMDNJ-Robert Wood Johnson University Hospital now has a Center for Alternative and Complementary Medicine. In addition, St. Peter's Medical Center and Morristown Memorial hospital have developed mind-body medical institutes. (Berlin, 1997) In Minnesota, the Hennepin County Medical Center established the Center for Addiction and Alternative Medicine Research in 1982. In addition, the University of Minnesota Academic Health Center established the University of Minnesota Center for Spirituality and Healing in 1997.

The establishment of the Office of Alternative Medicine within the NIH has added legitimacy to CAM, while another significant step in its growth in importance occurred when Oxford Health Plans became the first large medical insurer to offer a network of alternative medicine providers in New Jersey, New York, and Connecticut. (Moore, 1997)

The American Medical Association's resolution of 1995 suggesting its 300,000 members become better informed regarding the practice of techniques of alternative or unconventional medicine is a further indication of growing awareness of CAM. (Kennedy, 1997)

B. Why is the Interest in CAM Rising?

Practices that were once considered alternative, such as massage, chiropractic, and therapeutic application of nutrition, have become more accepted within mainstream medicine. Many acute care, long term care, and ambulatory care clinics are beginning to offer CAM. The types of therapies offered at such clinics include: massage, biofeedback, relaxation, acupuncture, herbal medicine, hypnosis, meditation, yoga, imagery, music therapy, and healing touch.

In Minnesota, many clinics are expanding their programs to include CAM. For example, Health Partners is adding complementary services to two clinics, Health East now has a healing arts center, Thai Chi is taught at United Hospital's Cardiac Rehabilitation Center, and Walker-Methodist and Redeemer Residence LTC facilities are implementing complementary modalities.

C. Opponents of CAM

Not everyone agrees that CAM represents an appropriate form of medical care. To some, many of the therapies considered CAM represent unscientific treatments that may at best be benign and at worst harmful (National Council Against Health Care Fraud, 1994.) The argument made against CAM is that if these therapies were to be proven scientifically valid, they would be adopted by allopathic medicine, and would become mainstream. Although

these opponents of CAM often admit that there are some CAM therapies that have been demonstrated to be effective, they maintain that supporting or validating all CAM allows unscrupulous practitioners to prey on unsuspecting patients who may be directed away from truly helpful medical treatments. One author discusses alternative medicine as quackery, and states that "Some people's needs have exceeded what ethical, scientific health care can provide. The main reason for quackery's success is its ability to seduce unsuspecting people. Much of its popularity comes from claiming credit for recovery from self-limiting ailments." (Barrett, 1994).

More moderate critics of CAM point to the relative lack of rigorous, controlled effectiveness studies, and call for caution in evaluating the usefulness of a therapy until more scientific evaluation can be conducted. See section III for a discussion of existing efficacy and safety studies of CAM.

D. Worldwide View of CAM

According to the World Health Organization (WHO) of the United Nations, between 65 and 80 percent of the world's health services currently would fall under the rubric of CAM. Pharmacists and medical doctors recognize that herbs and medicinal plants have been used to treat disease since the beginning of human-kind. (Kaul, 1996).

The WHO recognizes many different forms of CAM as legitimate therapies. For example, the WHO has listed over 100 different physical conditions treatable by acupuncture, including narcotic addiction, myopia, duodenal ulcer, trigeminal neuralgia, bursitis, osteoarthritis, and other pains. (Kaul, 1996)

The WHO also recognizes ayurveda, which is practiced all over the world. In India alone, there are over 300,000 physicians practicing ayurvedic medicine. (Kaul, 1996)

An estimated 500 million people in the world receive homeopathic medicine. The WHO has listed homeopathy as one of the traditional CAM treatments that, if integrated with modern medicine, will provide adequate health care across the globe in the future. (Kaul, 1996)

PART V: AVAILABILITY OF CAM

A. Availability of CAM in the U.S.

1. Current Numbers of Providers

In the U.S., CAM represents a significant and growing component of the health care industry. A study published in Health Affairs examined the availability of chiropractic, oriental medicine, and naturopathy providers in the U.S. This study estimates current and future numbers of providers in these three disciplines and projects that CAM providers will increase at a rate more than 5 times that of physicians between 1994 and 2010. (Cooper, 1996)

In 1970 there were 13,000 chiropractors (six per 100,000 population), who treated approximately 5.5 million patients (3 percent of the population.) By 1990 the number of chiropractors had tripled to 40,000 (sixteen per 100,000), and the number of their patients grew proportionately to 16.5 million. There were approximately 50,000 active chiropractors in 1994 (19.2 per 100,000). It is estimated that there will be over 100,000 chiropractors (33.2 per 100,000) by the year 2010.

In 1994 there were approximately 7,200 practitioners of oriental medicine (2.8 per 100,000) 6,500 of whom were licensed. There were 1,800 naturopaths in 1994 (0.7 per 100,000), 870 of whom were licensed. Naturopaths practice under the title "Doctor of Naturopathy" (N.D.) and are licensed in only twelve states. (One of these states, Florida, no longer issues new licenses.) However, naturopaths practice in at least twenty-eight states that have no licensure laws, sometimes under the supervision of a physician but frequently as independent practitioners.

Collectively, there were 59,000 alternative medicine clinicians practicing chiropractic, oriental medicine, and naturopathy in 1994-equivalent to 10 percent of the number of patient care physicians (including osteopaths) in that year.

Across the U.S. there is substantial variation in the availability of CAM providers. Distribution of chiropractors, the largest CAM provider group, ranges from 7 providers per 100,000 population in one state to 40 per 100,000 in another. (Cooper, 1996)

2. Trends for the Future

There is a general trend of increasing enrollment in schools offering training in each of these three disciplines. Combined enrollment in 1994 was 5,738. Adjusting for attrition, approximately 18 percent more chiropractic students are projected to graduate in 1998 than graduated in 1995. Among existing oriental medicine colleges, 8 percent more graduates are projected in 1998 than there were in 1995, and more colleges are expected. Graduates from the three naturopathic colleges have increased 15 percent over the past three years and are projected to increase by an additional 21 percent by 1998. The combined number of new clinicians who will graduate in the three disciplines is projected to grow 17 percent.

Overall, the per capita numbers of these three CAM provider types are expected to increase over the next 15 years by 88%. At the same time, the per capita increase in MDs is expected to be 16 percent.

B. Availability of CAM in Minnesota

Following is a chart which illustrates the current available training and number of providers for several CAM therapies in Minnesota. This chart indicates the availability for a few occupations which have organized associations or schools in this state, and is not meant to be exhaustive.

Table 1
1997 CAM Occupations in Minnesota: a partial listing

Occupation	State Licensure Required?	Professional Organizations in Minnesota	Training Available in Minnesota	Number of Graduates per Year	Number of Providers in Minnesota
Chiropractic	Yes ¹	Minnesota Chiropractic Association (612) 644-5929	Northwestern College of Chiropractic	250	1728
Massage/Oriental Bodywork	Currently regulated under widely varied municipal ordinances	American Massage Therapy Association - Minnesota Chapter (AMTA) Minnesota Therapeutic Massage Network (612) 879-4337	Aveda Day Spa Center for Balanced Life College of St. Catherine Eagle's Nest Institute Minnesota Center for Shiatsu Study Minneapolis School of Massage and Bodywork Mochizuki Institute of Oriental Medicine Northern Lights School of Massage Therapy Sister Rosalind Gefre's School of Professional Massage Touch of Life School of Massage	est. 600	est. 1,500-2,000
Homeopathy	No	Minnesota Homeopathic Association (612) 525-9321	Northwestern School of Homeopathy	25	10-12
Acupuncture	Yes ²	Acupuncture Association of Minnesota (612) 641-0467	Minnesota Institute for Acupuncture and Herbal Studies	10-15	74 ³
Naturopathic Physicians	No	Minnesota Association of Naturopathic Physicians (612) 222-4111			7
Traditional Naturopaths	No	Minnesota Coalition for Natural Health The Coalition for Natural Health--Minnesota Chapter (800) 586-4264			est. 130-302

1. Chiropractors have been regulated in Minnesota since 1919 under the Minnesota state Board of Chiropractic Examiners.

2. Acupuncturists have been regulated in Minnesota since 1997 under the State Board of Medical Practice, Acupuncture Unit.

3. In addition, 342 Chiropractors are registered with the Minnesota Board of Chiropractic to practice acupuncture.

Table 2

Clinical Physicians Licensed in Minnesota: 1996*

Area of Practice	Number of Physicians
Primary Care	4599
Specialty Care	5508
	Total: 10,107

**Source: Minnesota Department of Health, Office of Rural Health and Primary Care, November, 1997*

PART VI: UTILIZATION OF CAM

A. Utilization of CAM in the U.S.

A recent study provides evidence that the number of visits to providers of CAM in the U.S. exceeds the number of visits to all primary care physicians. (Eisenberg, 1993) L.C. Paramore published a study about the use of chiropractic, acupuncture, massage therapy, and relaxation therapies in the U.S. based on the Robert Wood Johnson Foundation National Access to Care Survey. Findings indicated that in 1994 almost 25 million persons (10% of the U.S. population) had seen a professional for at least one out of the four alternative therapies mentioned above. Of the estimated 25 million people who saw a CAM provider in 1994, over 70 percent had seen a provider of chiropractic. Adults (ages 19-64) tended to use CAM therapies more often than either children or the elderly, but examination of gender and race/ethnicity did not find significant differences.

Table 3
Percentage of Persons Seeing a Professional for Alternative Therapies, U.S., 1994

Type of Therapy	Percent of U.S. population	Number of persons (in millions)
Chiropractic	6.8	17.6
Therapeutic Massage	3.1	8.0
Relaxation Techniques	1.3	3.4
Acupuncture	0.4	1.0
At least one of the above	9.4	24.4

Source: Paramore L.C., Journal of Pain and Symptom Management, Feb. 1997)

Table 4
Percentage of Persons Seeing a Professional for Alternative Therapies by selected
Demographic and Socioeconomic Factors, United States, 1994
Source: (Paramore, 1997)

	Number of Persons (in millions)	Chiropractic %	Relaxation Techniques %	Therapeutic Massage %	Acupuncture %
All Persons	259.2	6.8	1.4	3.1	.4
Age (years)					
Children (1-17)	73.5	1.9	.6	.4	.1
Adults (18-64)	154.6	9.3	1.7	4.5	.4
Elderly (65 +)	31.1	6.5	1.5	1.5	.4
# of Conditions					
None	158.6	5.9	.7	2.1	.4
One or More	100.6	8.3	2.4	4.8	.5
Region					
Northeast	47.8	7.6	1.6	3.1	.2
Midwest	65.8	8.8	1.4	2.9	.4
South	92.6	4.3	.9	2.5	.2
West	53.1	8.1	1.9	4.5	1.2
Education					
High School or less	17.5	7.4	.8	2.9	0
Some post-high	141.2	6.4	1.8	3.5	.7
Income					
< 150% poverty level	32.7	4.3	.8	2.9	0
≥ 150% poverty level	204.6	7.4	1.5	3.1	.5
Private Insurance					
HMO/IPA	47.8	4.5	1.5	3.3	.2
PPO	32.0	8.3	1.1	3.3	1.0
Other FFS	89.8	8.6	1.5	3.6	.3

Persons with some post-high school education reported significantly higher use of relaxation techniques and acupuncture than did persons with a high school education or less. Less educated individuals reported more visits to chiropractors. Chiropractic use was significantly higher for persons with family incomes at 150% of the poverty level or higher than for persons with lower incomes. HMO enrollees were significantly less likely to visit a chiropractor (4.5%) than were members of preferred provider organizations and other fee-for-service plans. Differences in the use of CAM according to overall insurance coverage (i.e. Medicare, Medicaid, private insurance, and the uninsured) were not statistically significant. (Paramore, 1997) A mid-1996 survey of members belonging to Oxford Health Plans reported that one in three members visited an alternative medicine provider in the past two years. (Moore, 1997)

Approximately one in three Americans who see their medical doctors for a serious health problem may be using unconventional therapy in addition to conventional medicine for that problem. Seventy percent of these patients do not tell their medical doctors that they use unconventional therapy (Eisenberg, 1993)

B. Reasons for Utilizing CAM

According to one study, most users of alternative therapies believe they have explored the full utility of conventional Western approaches. "Most have chronic illnesses (e.g. cancer, HIV infection, or AIDS, arthritis, chronic pain, sinusitis, migraines) for which Western medicine can usually offer only symptomatic relief or palliation, not definitive treatment. Alternative therapies are often used in combination with the appropriate conventional approaches, as a way of enhancing and complementing them. Sometimes alternative approaches are used instead of conventional therapies when the latter have proved ineffective or have produced deleterious side effects." (Gordon, 1996).

Table 5
Use of Unconventional Therapy for the 10 Most Frequently Reported Principle Medical Conditions

Reported Condition	%	Used unconventional therapy in past 12 months	Saw provider in past 12 months	Therapies most commonly used
Back problems	20	36	19	Chiropractic, massage
Allergies	16	9	3	Spiritual Healing, lifestyle diet
Arthritis	16	18	7	Chiropractic, relaxation therapy
Insomnia	14	20	4	Relaxation techniques, imagery
Sprains or strains	13	22	10	Massage, relaxation techniques
Headache	13	27	6	Relaxation techniques, chiropractic
High blood pressure	11	11	3	Relaxation techniques, homeopathy
Digestive problems	10	13	4	Relaxation techniques, megavitamins
Anxiety	10	28	6	Relaxation techniques, imagery
Depression	8	20	7	Relaxation techniques, self-help groups
10 most common	73	25	10	Relaxation techniques, chiropractic, massage

**-Percentages are of those who reported the condition. -"Provider" denotes a provider of unconventional therapy(source: Gordon, 1996)*

According to Dr. Wayne Jonas, Director of the Office of Alternative Medicine, most patients who use CAM are not "alternative patients" but use CAM to supplement and support conventional medicine. CAM patients are people who look for options and seek out optimal and customized care. (Jonas, 1996)

The vast majority of persons in another study visited both a provider of CAM and an allopathic doctor for a specific condition. Nearly 95 percent of persons who sought help from an acupuncturist did so for a specific condition, as did over 70 percent of persons for other CAM therapies. Back, neck, and shoulder pain were the most frequently cited reasons for a visit to a CAM provider. Headaches, stress, and anxiety were also mentioned frequently. More than 70 percent of persons using relaxation techniques, therapeutic massage, or acupuncture also visited an allopathic doctor regarding their condition. However, less than half of the chiropractic users also consulted with an allopathic doctor regarding their specific condition. (Paramore, 1997)

C. Utilization in Minnesota

It is difficult to estimate how many people in Minnesota utilize CAM therapies. The only public utilization study of all CAM therapies in this state was conducted by Allina Health Systems at Abbott Northwestern in the Metro area.

According to the Abbott Northwestern Hospital Consumer Study from September 1995, two-thirds of Twin-cities' area households have used complementary therapies between 1993 and 1995. The study found that consumers between the ages of 35 to 44, current Preferred Provider Organization members, and those who have chronic conditions were more likely to use an alternative form of therapy. Vitamin supplements were the most commonly used forms of therapy in the Minneapolis/St. Paul metro area (40%). Consumers were then most likely to have used nutrition/dietary information (34%) Chiropractic, (33%), and body therapies (26%). The consumer study found that between 1993 and 1995, one in ten households or fewer have used hypnosis/guided imagery, yoga, oils, aromatherapy/essential oils, acupuncture/acupressure, herbal therapy/homeopathy and relaxation therapies. (National Research Corporation, 1995)

Twin Cities area consumers reported in the study that, in the future, they would most likely use vitamin supplements, nutrition/dietary modification, chiropractic, and body therapies. The consumer study also found that insurance coverage is the most important aspect to consumers in choosing a provider. (National Research Corporation, 1995.)

In addition to the Abbot Northwestern Hospital Consumer study, a survey of the 7 naturopathic physicians with four-year degrees in Minnesota indicated that each ND sees between 10-32 patients per week. (Healy, 1997)

An independent survey by Decision Resources, Inc. in 1996, revealed that 47 percent of all adults in Minnesota have sought treatment from a doctor of chiropractic. The independent survey also showed significant differences in usage throughout the state. Chiropractic treatment is most common in Greater Minnesota, with 54 percent usage, compared to 40 percent in the Twin Cities metropolitan area. The highest usage was found in southeastern Minnesota where 62 percent of the survey respondents reported having sought treatment by a chiropractic doctor. That was followed by 56 percent in southwestern Minnesota and 50 percent and 49 percent respectively in the northern seventh and eighth congressional districts.

Back trouble was most commonly mentioned as the reason which prompted a consumer to visit the chiropractic doctor, according to the survey by Decision Resources. (Minnesota Chiropractic Association, 1997)

D. Insurance Coverage in Minnesota

In the summer of 1996, the Center for Addiction and Alternative Medicine Research conducted a survey of Minnesota's Health Care Marketplace. The Center asked managed care plans, hospital/health care systems, preferred provider organizations, employers, purchasing pools, and government agencies to assess their level of knowledge about and interest in including alternative medicine in health plans coverage. Sixty-three percent of the 19 organizations interviewed said that they are currently in the process of expanding, or exploring how to integrate complementary medicine into the coverage offered within the market, or to their employees. The majority of the health care organizations in the study said that physician leadership and consumer demand will drive the availability of complimentary medicine in the current health care market. Seventeen of the 19 interviewed organizations

indicated that consumer satisfaction was the main advantage to including complementary medicine in their plan, coverage, or system. Cost benefit was also an important criteria in choosing to cover complimentary medicine for 15 of the organizations. (Center for Addiction and Alternative Medicine Research, 1996.)

A survey of the 7 naturopathic physicians in Minnesota with four-year degrees indicated that less than 5 percent of their services were covered by insurance. (Healy, 1997)

Chiropractic is included in all insurance and health maintenance plans licensed to do business in Minnesota as per MN Stat. 62A.15 and 62Q.23. The majority of health plan options include direct access to chiropractic doctors. (Minnesota Chiropractic Association, 1997)

E. History of CAM in Minnesota

Many of the therapies that make up CAM have had a long history in Minnesota. Below is a brief chronological outline of some of the key CAM activities in this state. Although undoubtedly many key dates are missing from this outline, what is represented here demonstrates that CAM is not new to Minnesota.⁵

- 1867 Minnesota State Homeopathic Institute founded in January.
- 1872 Ramsey County Homeopathic Medical Society organized in February.
- 1880 The Minneapolis Homeopathic Medical Society formed.
- 1881 The Homeopathic Medical Society of St. Paul formed.
- 1882 The Minneapolis Homeopathic Hospital formed. This was the hospital utilized for students of the Minnesota Homeopathic Medical College.
- 1886 Minnesota Homeopathic Medical College within the University of Minnesota founded in February.
- 1887 The St. Paul Clinical Society was organized by physicians attached to the St. Paul Free Homeopathic Dispensary.
- 1893 Dr. William Dechmann, a naturopath and graduate of the German Nature Cure System, came to the United States and set up his clinic in Minneapolis, Minnesota.
- 1894 The first osteopathic office in Minnesota opened in Red Wing by Harry and Charlie Still.

⁵This information was taken from the following publications: North Western Reporter (1933); J.A.M.A.'s Medical News (1929, 1931, and 1945); Herald of Health (1916); The Naturopath (1909, 1926, 1927, &1932); "Homeopathic and Eclectic Medicine in Minnesota." by James Eckman. Minnesota Medicine (1941). Information was also provided through written correspondence with Jerri Johnson, Minnesota Natural Health Coalition; Helen Healy, N.D.; Edith R. Davis, Diplomate in Acupuncture (NCCA); and Kendra Calhoun, Executive Director, Minnesota Chiropractic Association.

- 1899 The Minnesota Osteopathic Medical Society founded in 1899.
- 1909 The Board of Regents closed the Minnesota Homeopathic Medical College.
- 1909 Licensure for osteopathic physicians passed.
- 1919 Chiropractic granted licensure in Minnesota.
- 1925 Minnesota State Society of Naturopaths incorporated on January 26.
- 1927 Minneapolis College of Naturopathy incorporated in April.
- 1941 Northwestern College of Chiropractic (Bloomington, MN) founded in June.
- 1980 Application for licensure of acupuncturists first made to the Minnesota Department of Health.
- 1990 Minnesota Institute of Acupuncture and Herbal Studies opened.
- 1992 The first granting of allied staff privileges to a doctor of chiropractic (Moose Lake Hospital).
- 1997 Licensure of acupuncturists officially established on July 1.

PART VII: REGULATION OF COMPLEMENTARY MEDICINE

A. The Purpose of Regulation of Health Professions

The traditional reasons for the regulation of health care professions are to prevent non-diagnosis, misdiagnosis, non-treatment and mistreatment by unlicensed medical providers. The aims of the regulatory mechanism are: 1) protecting the public from the dangers of unskilled practitioners and unsound treatment or advice; and 2) protecting the public from reliance on unskilled practitioners, as well as directing them to proper medical care. (Cohen, 1996)

Some legal experts consider these goals to be paternalistic—that consumers are unable to distinguish between competent practitioners and quacks, and therefore must rely on the state to do so. (Cohen, 1996) This theory of licensing is referred to as the public-interest theory of licensing, which assumes that the two basic objectives of government are to improve efficiency, and to redistribute income in a more equitable manner. (Capen, 1997)

An opposing theoretical view of legislation is the “self-interest” paradigm which assumes that individuals act according to self-interest, not necessarily in the public interest. In this view, legislation occurs to achieve the status and other professional goals of an occupational group, with public protection a secondary or incidental benefit.

Another argument for licensing/regulating is based on the “asymmetry of information” that is prevalent in occupational service markets. According to this argument, suppliers of services are able to manipulate consumers because they know more about the quality of their services than the consumers. Thus, licensing helps increase supply of high quality practitioners and decrease consumers costs of searching for quality providers.

In Minnesota, the purpose of regulating any occupation is to protect the public. Minnesota Statutes §214.001, subd. 2, states “The legislature declares that no regulation shall be imposed upon any occupation unless required for the safety and well being of the citizens of the state.” The statute also enumerates four criteria for evaluating whether an occupation should be regulated. As a statement of legislative policy, consideration of regulating occupations begins with a bias against regulating.

B. Types of Regulation of Health Professions

There are five main types of regulation traditionally used to regulate health professions, and these are discussed individually below.

1. Permit

This is called registration in some states. Under this type of regulation, any person may engage in an occupation, but he or she is required to submit information concerning the location, nature, and operation of the practice. A permit system is an appropriate form of regulation when the threat to life, health, safety and economic well-being is relatively small and when other forms of legal compensation are available to the public. In its simplest form,

a permit is a device for record keeping and for informational purposes. Persons engaging in a particular activity may be required to "register" with a regulatory agency. This means that anyone may engage in that particular activity, but having entered upon it, that person is under an obligation to inform the agency of that fact, to tell the agency what he or she is doing, who he or she is, and where he or she is located. This way, the agency is able to supervise the activity if necessary. A permit system, therefore, imposes no prior condition for entering a particular field, creates no limitations on who can enter the field, regardless of qualifications, and imposes few if any future conditions on continuing occupational activity. A permit system in this form does little more than provide a roster of practitioners and a means for disciplining these professionals.

2. Inspection

This regulatory system subjects the activities and premises of persons in certain occupations to periodic inspections to ensure that the public's health, safety, and welfare are protected. Anyone is allowed to practice the occupation without meeting specific entry criteria. However, an injunction can be issued to prevent persons who do not meet the inspection standards from engaging in these occupations. One example is providers of food and beverage services, whether from a restaurant, bar, or state fair booth.

3. Registration

In Minnesota, registration recognizes persons who have met certain educational and experience standards to engage in an occupation. Although any one may practice the occupation, only those who are registered may use the occupational title. Registration is especially appropriate when the public needs assistance in identifying competent practitioners, but where the risks to health and safety are not severe enough to warrant licensure. Most other states in the United States use the term certification to refer to such regulation. These states define registration as Minnesota defines permit.

While registration is sometimes referred to as "voluntary" regulation because it does not dictate who can perform occupational functions, as a regulatory scheme registration can be very restrictive if use of generic and all reasonably related titles is limited to only those persons meeting predetermined standards established by the state. Registration may be permissive occupational regulation if very few occupational titles are protected and reserved to qualifying persons.

The elements of registration systems can be as complex and extensive as licensure regulations. In Minnesota Statutes §214.13, subd. 3, registration may include "procedures and standards relating to the registration requirement, the scope of authorized practice, fees, supervision required, continuing education, career progression and disciplinary matters."

4. License

Under this method of regulation, it is illegal for anyone to engage in an occupation without a license, and only persons who possess certain qualifications are licensed. Licensure systems are appropriate where the unlicensed practice of an occupation poses a serious risk to the life, health and safety, or economic well-being of the public and the risk of harm is directly related to the degree of skill and training necessary to competently perform occupational functions; where the potential user of an occupational service cannot be expected to possess the

knowledge needed to properly evaluate the qualifications of those offering services; and where the benefits of reduced potential for harm to the public from the unlicensed practice of an occupation clearly outweigh any potential harmful effects, such as a decrease in the availability of practitioners, or high costs of goods and services.

Licensing laws are often called "practice acts" because they grant authority to licensees to engage in certain practices within a profession. Once the scope of practice is established by law, it is illegal for anyone without a license to perform any of the activities covered by the law. (Young, 1987)

The license not only qualifies the licensee to practice the profession as defined in the statute, but also subjects the licensee to the designated procedures and penalties for misconduct. Professional misconduct includes such acts as obtaining the license fraudulently, practicing the profession fraudulently, beyond its authorized scope, with gross incompetence, or with gross negligence, committing unprofessional conduct, practicing while impaired by alcohol or drugs or while convicted of a crime, permitting or aiding an unlicensed person to perform activities requiring a license, or failing to comply with relevant rules and regulations. State statutes frequently include any departure from the standards of acceptable and prevailing medical practice within the definition of unprofessional conduct. (Cohen, 1996)

Proponents of licensure argue that governments have a responsibility to protect the public from harm and to ensure the availability of high-quality goods and services. Critics of governmental regulation, on the other hand, believe that licensing boards use their powers to restrict the supply of practitioners. According to some consumers, these restrictions can raise the cost of obtaining these goods and services. (Shimberg, 1978)

5. Certification

In many states, certification is the name given to the type of regulation Minnesota defines as registration, in other words, a regulatory scheme which limits use of an occupational title to persons who meet predetermined standards of education or training. Nationally, certification is also a term used by private credentialing organizations which establish a property interest via trademark, service mark or copyright in a word or set of words denoting occupational specialty. Separately, and sometimes furthering confusion, academic and other training programs confer "certificates" or "certified" status upon students completing a course of study.

In Minnesota, certification as a system of regulation is not defined in statutes. However, the legislature has enacted certification systems to regulate two occupations in a manner that is most similar to licensure in restrictiveness. Specifically, the licensure-like elements include prohibitions against performing occupational functions unless the practitioner can pass a competency based examination. Additional requirements for maintaining certification include continuing education requirements and meeting legal standards for professional and ethical conduct. The certification systems currently in law do not specify titles to be used in practice, but prohibit any misrepresentation of qualifications. To enforce the requirements, certification regulations authorize investigative and disciplinary action.

C. Medicine and Regulation

The regulatory system, in its licensing scheme for physicians, prescribes the qualifications of who may practice medicine, including the power to establish licensing boards that admit or exclude persons from the medical profession, based on the justifications of preventing indiscriminate conduct by "unskilled and unlicensed practitioners" and in the general interests of public protection.

While each state has its own version of the definition of the "practice of medicine," all state statutes include some combination of the following: (1) diagnosing, preventing, treating, and curing disease; (2) holding oneself out to the public as able to perform the above; (3) intending to receive a gift, fee, or compensation for the above; (4) attaching such titles as "M.D." to one's name; (5) maintaining an office for reception, examination, and treatment; (6) performing surgery; and (7) using, administering, or prescribing drugs or medicinal preparations. The sections below briefly describe some of the permutations. (Cohen, 1995)

In contrast to broad "practice of medicine" statutes, statutes defining allied health professionals are defined narrowly, with express prohibitions against "practicing medicine." Allied health professionals fall into three groups:

1. Specialists whose practice generally would be considered within the parameters of medical orthodoxy (such as nurses and dentists);
2. Assistants to physicians, and specialists, typically under physician supervision (such as physician assistants and respiratory therapy technicians); and
3. Specialists whose practice might fall within the realm of "alternative," "unconventional," or "unorthodox" medicine (such as chiropractors and acupuncturists).

While physicians have unlimited authority to "diagnose" and "treat," allied health professionals have a limited range of activity, and in many cases, can practice only under physician supervision. (Cohen, 1995)

D. Regulation and CAM

The history of regulation of the health care professions shows that the CAM movement emerged into prominence in the early 1970's. Prior to 1970, there was public and regulatory consensus on the nature and definition of medical science; the vast majority of persons engaged in the practice of medicine were allopathic MD's grouped in local and state medical societies, and were represented by the American Medical Association. The main competing groups during this time were osteopaths and chiropractors. Naturopathic physicians were licensed in a very few states. Osteopaths were licensed in all fifty states. By the end of the 1970's, chiropractic had become one of the country's largest CAM professions; and had been licensed in all 50 states. It was also included in Medicare, Medicaid, Government employment insurance, and most private health care coverage. (Caplan, 1991)

A small number of homeopathic MD's practiced homeopathic medical science within the scope and protections afforded by the incorporation of the homeopathic pharmacopoeia in the 1938 US Food, Drug, and Cosmetic Law. (Coulter, 1997)

Today, alternative health care providers such as chiropractors, acupuncturists, homeopaths, naturopathic physicians, and massage therapists are credentialed in several states. For example, chiropractors and osteopaths are licensed in every state and Washington D.C., massage therapists are licensed in about half of the states, acupuncturists are licensed in around 34 states, 12 states license naturopathic physicians, and 4 license homeopaths, while several others include homeopathy within the definition of other health care professionals. (Cohen, 1996 and Eisenberg, 1997)

The table below lists five CAM systems - chiropractic, acupuncture, massage therapy, homeopathy and naturopathic medicine, and the states that have licensed them.

Table 6
State Licensure and Registration of Alternative Medicine Providers

State	Chiropractic	Acupuncture	Massage Therapy	Homeopathy	Naturopathic Medicine
Alabama	X				
Alaska	X	X			X
Arizona	X	X		X	X
Arkansas	X		X		
California	X	X			
Colorado	X	X			
Connecticut	X	X	X	X	X
Delaware	X		X		
Washington, D.C.	X	X	X		X
Florida	X	X	X		
Georgia	X				
Hawaii	X	X	X		X
Idaho	X				
Illinois	X	X			
Indiana	X				
Iowa	X	X	X		
Kansas	X				
Kentucky	X				
Louisiana	X	X	X		
Maine	X	X	X		X

State	Chiropractic	Acupuncture	Massage Therapy	Homeopathy	Naturopathic Medicine
Maryland	X	X	X		
Massachusetts	X	X	X		
Michigan	X				
Minnesota	X	X			
Mississippi	X				
Missouri	X				
Montana	X	X			X
Nebraska	X		X		
Nevada	X	X		X	
New Hampshire	X	X	X		X
New Jersey	X	X			
New Mexico	X	X	X		
New York	X	X	X		
North Carolina	X	X			
North Dakota	X		X		
Ohio	X		X		
Oklahoma	X				
Oregon	X	X	X		X
Pennsylvania	X	X			
Rhode Island	X	X	X		
South Carolina	X	X	X		
South Dakota	X				
Tennessee	X	X	X		
Texas	X	X	X		
Utah	X	X	X		X
Vermont	X	X			X
Virginia	X	X	X		
Washington	X	X	X	X	X
West Virginia	X	X			
Wisconsin	X	X			
Wyoming	X				

(Excerpted from: Eisenberg, David M, "Advising Patients who seek Alternative Medical Therapies" *Annals of Internal Medicine*, 1997, vol 127, #1)

E. Recent/Current Regulations of CAM Nationwide

Over 100 separate health occupations and professions are regulated in one or more states and 15 occupations are licensed in all 50 jurisdictions. In addition, 14 specialties are regulated in a majority of the states. Each year, legislation is introduced in nearly every state legislature to regulate additional health occupations and to amend existing laws. (Carpenter, 1993)

An overview of the existing regulations pertaining to CAM nationwide was conducted by David M. Sale, with the support of The John E. Fetzer Institute. The study describes state-level statutory developments for four modalities regulated by provider practice acts, and 27 alternative forms of therapy which are referenced in the scope of practice for other regulated modalities. The study also highlights selected federal laws governing specific modalities. A summary description of the types of regulation offered in other states, based on this study, can be found in Appendix D.

Alternative health care legislation currently exists in three categories in the United States:

- 1) Provider practice acts regulating a particular alternative modality comprehensively through licensure, registration, or certification;
- 2) Single references to specific complementary therapies or techniques generally in the content of a statute that defines the scope of practice for a more systematically regulated modality.
- 3) Provisions of medical practice or uniform disciplinary acts conditionally authorizing physicians or other providers to employ unspecified alternative therapies. (Sale, 1994)

The form of legislative authorization by which a state chooses to sanction practice of an alternative modality may be through licensure, certification, or registration with the appropriate administrative entity. A fourth option would be to create Freedom of Practice legislation that would allow providers to continue providing services as long as the service is not shown to be dangerous or harmful.

F. Licensing of Health Professions in Minnesota

1. Minnesota Statute Chapter 214: Examining and Licensing Boards

The legal criteria for occupational regulation in the state of Minnesota are found at the beginning of Minnesota Statutes, Chapter. 214 (1996). This is the umbrella chapter which governs occupational examining and licensing boards. The statutory criteria are based on two principles:

- 1) Do not regulate an occupation unless it is necessary to protect the safety and well being of Minnesotans.
- 2) If it is necessary, use the least restrictive form of regulation possible.

Minn. Stat., 214.001, subd. 2 states that, *The legislature declares that no regulation shall be imposed upon any occupation unless required for the safety and well-being of the citizens of*

the state. That subdivision also lists questions lawmakers should consider in determining whether regulation of a given occupation is necessary. The questions include: whether the public would be adversely affected if the occupation is practiced incompetently, carelessly, or unethically; whether the occupation requires special training, education, or experience to assure that its practitioners are competent; whether there might be another way to protect the public; and whether regulation would be cost-effective and economically beneficial to the public. (McCormick, 1997)

In Minnesota, once the Legislature concludes that an occupation should be regulated, the law requires the use of the least stringent form of regulation that will provide the needed protection for the public. Minn. Stat., 214.001, subd.3 (1996). The first form of regulation to be considered must be the creation or extension of causes of civil action or of criminal prohibitions. If that is not seen as adequate, the next form to be considered is the imposition of inspection requirements and the ability to enforce violations by injunctive relief in the courts. If that still isn't adequate, the Legislature should consider a system of registration or certification, under which practitioners of the occupation would be permitted to use a designated title only after meeting certain requirements and being listed on an official roster. (McCormick, 1997)

Only if all of the less-stringent options are found to be inadequate should the Legislature resort to licensure of the occupation. Under licensure, the law typically identifies certain activities or procedures that constitute the practice of the regulated occupation. Then it sets out the education, training, or experience needed for the competent practice of the occupation. It usually requires aspiring practitioners to pass an examination upon completion of their training. Finally, it declares that only persons who are licensed may practice the occupation, and it usually makes practice by an unlicensed person a criminal offense. One result, of course, is that the public can be confident that everyone who practices the occupation is at least minimally qualified to do so. Another result, however, is that the pool of people available to perform the functions and provide the services of the licensed occupation is limited, and the price of those functions and services usually rises.

Chapter 214 goes on to establish a general framework for occupational licensing by independent boards, consisting mainly of representatives of the regulated occupations, with a minority of public members. Typically, those boards are linked, for administrative purposes, to state departments. Chapter 214 does not govern a comprehensive list of occupations, however. Often responsibility for regulation is assigned to an existing executive agency, most often the Department of Health or the Department of Commerce. (McCormick, 1997)

Finally, a list of causes for disciplinary action is usually established for each regulated occupation, by statute, rule, or both. (McCormick, 1997)

2. Current Regulation of Health Occupations in Minnesota

Among the states' historic police powers is the power to protect the health and safety of their citizens, including the power to "legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." Metropolitan Life Insurance Company v. Massachusetts, 471 U.S. 724, 756 (1995). As part of those broad police powers, the legislature typically decides which health related professions are to be regulated, defines the general parameters of

the regulation, usually by enacting a practice act for a particular profession, and establishes and/or delegates authority to administrative agencies to regulate the profession.

The practice acts usually specify the scope of practice for the specific profession, set forth minimal education or experience qualifications for licensure, and establish a licensure board or agency to actually administer the licensure program. Minnesota has recognized a number of health professions and established a variety of credentialing programs for the professions. The Minnesota legislature defines "health-related licensing boards" to include the following:

- 1) Board of Examiners for Nursing Home Administrators, Minn. Stat. §144A.19;
- 2) Board of Medical Practice, which also regulates physician assistants, acupuncture, practitioners, midwifery, physical therapists, athletic trainers. Minn. Stat. ch. 147 and Minn. Stat. §148.30-2;
- 3) Board of Chiropractic Examiners, Minn. Stat. §§ 148.01-106;
- 4) Board of Nursing, Minn. Stat. §§148.171-285;
- 5) Board of Optometry, Minn. Stat. §§148.52-62;
- 6) Board of Dietetics and Nutrition Practice, Minn. Stat. §148.621-633;
- 7) Board of Psychology, Minn. Stat. §148.88-905;
- 8) Board of Marriage and Family Therapy, Minn. Stat. §148B.29-39;
- 9) Board of Social Work, Minn. Stat. §148B.19-28;
- 10) Board of Dentistry, Minn. Stat. ch. 150A;
- 11) Board of Pharmacy, Minn. Stat. ch. 151;
- 12) Board of Podiatric Medicine, Minn. Stat. ch. 153;
- 13) Office of Mental Health Practice, Minn. Stat. §148B.61;
- 14) Chemical Dependency Counseling Licensing Advisory Council, Minn. Stat. §148C.02; and
- 15) Board of Veterinary Medicine, Minn. Stat. § 156.01.

In addition to those credentialing boards, the Commissioner of Health also registers some health professions, such as speech-language pathologists and audiologists, Minn. Stat. §148.511; alcohol and drug counselors, Minn. Stat. §148C.02; and funeral directors, Minn. Stat. Ch. 149.

Individuals who wish to practice one of the above professions or use a protected title must comply with the relevant statutes. Those who fail to comply with this system may find themselves faced with a variety of legal actions ranging from criminal prosecution for the unauthorized practice of a profession, to a court order enjoining their activities.

Minn. Stat. ch. 146 defines the "practice of healing" and provides that any person who attempts to "practice healing in this state without having registered with the examining board. . . shall be guilty of a misdemeanor." Minn. Stat. §146.18. One of the broadest practice acts is the medical practice act. Individuals who offer complementary or alternative medicine may find themselves charged with the unlicensed practice of medicine, which is punishable as a gross misdemeanor.

Minn. Stat. §147.081 provides that: "it is unlawful for any person not holding a valid license issued in accordance with this chapter to practice medicine as defined in subdivision 3 in this state." The practice of medicine is defined as the following:

- 1) advertises, holds out to the public, or represents in any manner that the person is authorized to practice medicine in this state;
- 2) offers or undertakes to prescribe, give, or administer any drug or medicine for the use of another;
- 3) offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, method, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, or defect of any person;
- 4) offers or undertakes to perform any surgical operation including any invasive or non-invasive procedures involving the use of a laser or laser-assisted device upon any person;
- 5) offers or undertakes to use hypnosis for the treatment or relief of any wound, fracture, or bodily injury, infirmity, or disease; or
- 6) uses in the conduct of any occupation or profession pertaining to the diagnosis of human disease or conditions, the designation "doctor of medicine," "medical doctor," "doctor of osteopathy," "osteopath," "osteopathic physician," "physician," "surgeon," "M.D.," "D.O.," or any combination of these designations.

Minn. Stat. §147.081, subd.3. There are certain exceptions to this very broad definition of the practice of medicine, including:

- any person licensed by a health related licensing board, as defined in section 214.01,
- subdivision 2, or registered by the commissioner of health pursuant to section 214.13, including psychological practitioners with respect to the use of hypnosis; provided that the person confines activities within the scope of the license. Minn. Stat. §147.09(9).

Any person who engages in the unlawful practice of medicine by performing any of the above-described practices or procedures is guilty of a gross misdemeanor. Minn. Stat. §147.081, subd. 2. The penalty for a gross misdemeanor carries a maximum fine of \$3,000.00, and subjects an individual to imprisonment for not more than one year. Minn. Stat. §609.03 (2).

The Medical Practice Act has been challenged as being unconstitutionally vague. However, the Minnesota Court of Appeals has found that "although the statute covers a broad range of activities, we believe Minn. Stat. §147.081, subd. 3 (3), is written with sufficient particularity to show conduct which is prohibited." State v. Saunders, 542 N.W. 2d 67, 70 (Minn. App. 1996).

In addition to the criminal sanctions described above, the Minnesota Attorney General's Office has initiated several consumer protection actions on behalf of the State of Minnesota against individuals who have held themselves out as offering diagnosis or treatment of disease, and/or offering a product or service to treat or cure a disease. Those actions were brought under the Deceptive Trade Practices Act, Minn. Stat. §§325D.43-48 and the Consumer Fraud Act, Minn. Stat. §325F.69. Typically the state seeks a declaratory judgment that the defendant has engaged in deceptive trade practices and consumer fraud in violation of Minnesota law, an injunction against the practice, and civil penalties, which can be awarded in the amount of \$25,000.00 for each separate violation.

The Minnesota Supreme Court has held that naturopaths who offer to diagnose and treat patients conditions through alternatives to traditional medicine may be engaged in the unlawful practice of medicine if they are not duly licensed in this state. *Shenk v. State Board of Examiners in the Basic Sciences*, 250 N.W. 353 (Minn. 1933).

Health licensing boards have authority to take legal action against their licensees if those licensees fail to comply with accepted standards of conduct. For example, "conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established" may subject a licensed health professional to disciplinary action by the Board of Medical Practice. Minn. Stat. §147.091, subd. 1(g). Substandard practice may subject a licensed health professional to further disciplinary action by their licensing board. Practice acts typically provide that departure from acceptable and prevailing practice is unprofessional conduct which subjects licensed professionals to formal discipline. *See* Minn. Stat. §147.091, subd. 1(k) and Minn. Stat. §148.261, subd. 1(6). Some alternative practices, such as chelation therapy or laetrile therapy for the treatment of cancer, performed by licensed medical doctors, have subjected those doctors to disciplinary actions by their licensing boards.

G. Existing Regulation of CAM Therapies in Minnesota

Of the many CAM professions being included in this report, chiropractic and acupuncture are the only professions that are currently licensed in Minnesota.

1. Regulation of Chiropractic

The chiropractic profession in Minnesota is regulated by the Minnesota Board of Chiropractic Examiners (MBCE). The chiropractic scope of practice is found at MN Stat. 148.01. MN Rule 2500.3000 details the process for chiropractic doctors to be registered by the MBCE to perform acupuncture. Additional MN Rules give clarification to rehabilitative therapies and other definitions within the chiropractic practice.

Minnesota licensure for chiropractic doctors, which was first established in 1919, requires passage of Parts I through IV of the National Board of Chiropractic Examiners examination Minn. R. 2500.0720. Part I of the exam covers the basic sciences. Parts II, III and IV include extensive testing in the following subjects: case history, vital signs; head and neck

examinations; thorax and lung examination; cardiovascular examination; abdominal examination; rectal and urogenital examination; clinical diagnosis, including head, eyes, ears, nose and throat; respiratory diseases; cardiovascular diseases; gastrointestinal diseases; genitourinary diseases; infectious diseases; laboratory interpretation, including urinalysis, hematology and serology; orthopedic examination, including the extremities; neurology examination, including sensory function and reflexes, and sexually transmitted diseases.

Additionally, chiropractic doctors are required to attain at least 40 hours of continuing education on a biennial basis in order to be relicensed each year. At least six of the continuing education hours must be devoted to radiology safety, technique, and/or interpretation; two hours to infection control, including blood borne pathogens; and eight hours in the establishment of professional boundaries in the clinical setting, and the identification and reporting of child and vulnerable adult abuse and maltreatment. The remaining hours must be in clinical topics, on documentation or workers' compensation. The MBCE reviews and grants/denies approval for all organizations or individuals who wish to offer chiropractic continuing education programs for re-licensure credit in Minnesota. Courses dealing with administrative and economic aspects of practice are not available for relicensure credit.

2. Regulation of Acupuncture

In Minnesota, as of June 30, 1997, it is unlawful for any person to engage in the practice of acupuncture without a valid license. In order to be licensed, acupuncturists must pass an exam given by the National Commission for the Certification of Acupuncture (NCCA). In addition, they must pass a clean needle technique exam given by the state, receive annual education on blood-borne diseases and continue to maintain and upgrade their education on the practice of acupuncture.

a. Scope of Practice The acupuncture statute in Minnesota allows acupuncturists to use the broad body of knowledge from the 3,000-year-old traditions of traditional Chinese medicine. The scope of practice includes developing a plan to treat a patient using Oriental medical theory, acupressure, cupping (a procedure that creates a vacuum against the skin using jar-shaped instruments), dietary counseling and herbal therapy based on traditional Chinese medical principles, breathing techniques, and exercise.

b. Administrative Structure After trying for several years to get licensed under the state health department, the acupuncture association decided to ask the state board of medical practice to license acupuncturists. The acupuncturists pay annual license fees of \$150 under the state board, compared with projected fees of \$600 if they had created their own self-supporting board. The board of medical practice is advised by a council of seven members. The requirements for membership of the council includes: four licensed acupuncture practitioners, one licensed physician or osteopath who also practices acupuncture, one licensed chiropractor who is NCCA certified, and one acupuncture consumer.

c. Practice Rights—Other Providers Physicians, osteopaths, chiropractors, persons studying in a formal course of study, and, under certain circumstances, visiting acupuncturists from other states may practice acupuncture within the scope of their practice without an acupuncture license.

3. Attempt to Regulate Naturopathic Physicians⁶

The first endeavor to secure legislation of naturopaths occurred in St. Paul, Minnesota in January 1909. The bill to be introduced created a State Board of Naturopathic Examiners to regulate the practice of Naturopathy in the state of Minnesota, to license Naturopathic Physicians, and to punish persons violating the provisions of the act. The Naturopathic licensure bill never passed. In 1927, however, the Minnesota Legislature enacted the Basic Sciences Act. Under this law, naturopathic practitioners were entitled to the benefit of registration in Minnesota if they passed the Basic Sciences examination. In 1974 much of the Basic Sciences Act (Chapter 146) was repealed and the title of the chapter became "Healing Arts, Registration." Under the new title, naturopaths had no mechanism for registration.

In 1980, Dr. Thomas Stowell and Dr. James Farr III came to St. Paul to open up the Wellspring Naturopathic Clinic. They formed the Minnesota Association of Naturopathic Physicians (MANP) and began work on licensing Naturopathic Doctors (N.D.s) in the state.

In 1987, the Human Services Occupations Advisory Council (HSOAC) began an evaluation of whether to license naturopathic medicine.

In February 1988, the HSOAC voted against a recommendation for licensure of Naturopathic Physicians in Minnesota.

In 1992, Dr. Stowell and Helen Healy, N.D. were charged with "practicing medicine without a license" by the Minnesota Board of Medical Practice. In 1993 the MANP submitted a bill for the licensure of Naturopathic Physicians, but was unable to see it through. In 1996, Helen Healy was again charged with "practicing medicine without a license" and taken to Civil Court. A settlement was reached outside of court that allows Healy to see patients at her holistic clinic in St. Paul as long as she abides by limits on her practice. In 1997, the MANP submitted another Naturopathic Licensing Bill which was not passed.

4. Attempt to Regulate Traditional Midwives

Traditional Midwives, as opposed to nurse midwives who are licensed by the Minnesota Board of Nursing, are not currently regulated in Minnesota. Though the Minnesota Board of Medical Practice (BMP) has statutory authority to license midwives, it has not done so for the past several decades, having last issued a midwifery license in the 1940's. In the absence of activity by the BMP, the legislature has heard bills to license traditional midwives several times during the 1990's. The bills have not passed out of policy committees, and the future of regulation for traditional midwives resides with the BMP. In the last several years, the BMP has made several efforts to establish standards to determine competency for traditional midwives, a major obstacle until 1996, when a national examination became available.

⁶This information is taken from the following publications: North Western Reporter (1933), J.A.M.A.'s Medical News (1929,1931,&1945), Herald of Health (1916), The Naturopath (1909, 1926, 1927, &1932) and personal correspondence with Helen Healy, N.D.

During 1997, the BMP has convened a task force to write statutory provisions defining the scope of practice and establishing entry and supervision requirements for traditional midwifery practice. The BMP now intends to introduce legislation in the 1999 session. The proposed legislation will either set entry, supervision and other practice requirements for traditional midwifery or relieve the BMP of licensure responsibility if the task force cannot draft regulatory language satisfactory to the BMP.

5. Attempt to Regulate Massage Therapists

Many local units of government regulate massage activity, however, in many cities the regulation is for the purpose of preventing or controlling illegal activity. Massage as a therapeutic health care service is regulated in a few cities, mostly located in the Twin City metropolitan area. At present, state regulation of massage does not exist. A bill to license massage therapists was introduced in the 1997 legislative session but did not receive a hearing.

H. Implications of Regulation

The potential regulation of any health profession has numerous implications for consumers, providers and society as a whole. Sometimes in discussions of the implications of regulation, the interests of consumers and providers conflict, while at other times, they coincide. Any specific regulatory proposal must be evaluated for its effects on society as a whole. In general, negative effects often include restrictions of legal rights of individuals and economic costs to consumers, practitioners, provider organizations, payers and others. Positive effects may include improvements in quality, access and information about providers and their services.

1. Benefits of Regulation

Regulation of a health profession could, at least in theory, have a number of benefits.

Improved quality of care. First, the regulation might improve the quality of care consumers receive, as unqualified or unethical providers are eliminated. Consumers could be protected from unknowingly seeking care from an untrained or unskilled provider.

Better information for consumers and health care decision makers. Consumers may have access to more information on what type of training should be expected for a provider of a certain type of care. Consumers might have better ability to seek out providers with appropriate training and skills. Regulatory systems such as licensure, certification and registration assist third party payers to efficiently identify qualified practitioners. In addition, they create databases which facilitate the monitoring of practitioner geographic distribution and specialty which can assist public health agencies in planning.

Protection of Providers from claims of practicing medicine without a license. Providers who are regulated would not be subject to legal action for practicing within the scope of their profession.

Continued/expanded access to CAM therapies. Because providers would be protected from legal action (see above) providers could be more likely to remain in practice, and consumers could continue to have access to their services.

Expanded coverage of health care services. When government sets standards for entry to and practice of an occupation, the “recognition” often becomes a basis for third-party payers, health care plans, and managed care organizations to pay or provide the services for insureds and enrollees.

2. Costs of Regulation

Regulation can limit the number of providers. Regulatory schemes such as licensure, certification, or registration deprive the public at large of specific liberty rights associated with practicing an occupation and give back to limited numbers of individuals a property right in the form of a credential. Depending on the type, regulation may be more or less restrictive. As the most restrictive type of regulation, licensure essentially gives a professional and economic monopoly to persons who meet the qualifications established by the legislature. In addition, limited numbers of practitioners may mean **limited consumer access** to the services

Regulation may increase the cost of services. By imposing training, education and other standards, entry into a profession is restricted and new costs of entry may be imposed which must be recovered by the practitioner in fees for services. Increasing costs of services to consumers may limit some consumers access to the service.

The regulatory system can be expensive. For those regulated fees may be high. Presumably regulatory fees, as a cost of doing business, are passed on to consumers of the services. Practitioner compliance and reporting requirements may be burdensome, further adding to the cost of providing the services.

The regulatory structure can **restrict the types of activities** of those providers regulated. Limitations on scope of practice, in other words the activities the practitioner is qualified or otherwise may provide, may reduce market and provider organization flexibility and efficiency.

I. Interplay of Regulatory and Economic Variables

The various benefits and costs of regulation outlined above may or may not apply to a specific regulatory approach. In some cases, the overall benefits significantly outweigh the costs. In other cases, the overall costs significantly outweigh the benefits. In CAM the largest difficulty may be that the majority of the costs may be incurred by one group while the benefits accrue to another. Weighing these factors will be an important part of consideration of regulation of any particular therapy or provider group. In particular, it may be possible to

craft regulatory or other options which result in many of the benefits or regulation at a lower cost. For example, it may be possible to protect the interests of a particular group of providers with a registration system rather than licensure. This could, if successful, avoid putting practitioners out of business and would potentially have a smaller impact on costs of services.

For another provider group, it may be the case that registration would not be sufficient to protect the public safety, and a licensing system may be required.

As an example of the implications of regulation, the Federal Trade Commission reported in a study of the costs and benefits of occupational regulation that: *When properly designed and administered, occupational licensing can protect the public's health and safety by increasing the quality of professional services through mandatory entry requirement--such as education--and business practice restriction--such as advertising restrictions. This report finds, however, that occupational licensure frequently increases prices and imposes substantial costs on consumers. At the same time, many occupational licensing restrictions do not appear to realize the goal of increasing the quality of professional's services. While the majority of the evidence indicates that licensing proposals are not often in the consumers' best interest, we cannot conclude that the costs of licensing always exceed the benefits to consumers. In considering any licensing proposal, it is important to weigh carefully the likely costs against the prospective benefits on a case by case basis.* (Cox, 1990.) If the impediments are not justified by gains in quality or health and safety there are social costs as well, since individuals are perhaps not permitted to work to their full potential.

Economic studies have documented increased costs associated with restrictions imposed by occupational regulation, particularly in the autonomous (such as medicine, dentistry and optometry), as opposed to employed health professions. There is little empirical work on whether regulation results in improvements in quality that outweigh the costs imposed.

Despite the fact that the main reason/argument for regulation is protection of the public, occupational regulation is typically sought by practitioners rather than imposed by outside forces. Regulation would appear to provide benefits to both practitioners and their professional associations. These benefits include enhanced status and prestige, and a focus for continuing education and other enhancement of professional skills.

Licensing and credentialing also impose costs on practitioners and workers. For regulated occupations and professions these costs include: licensing fees, association dues, examination fees, training costs and costs of continuing education courses. For those in lower paid occupations these costs can be a great burden. For unregulated workers licensing may limit job opportunities.

Costs are imposed on both credentialed and non-credentialed workers to the extent that licensing and credentialing prevent entry into health care occupations and block upward mobility within and across occupational groupings.

J. Occupational Regulation and Health Care Reform

Health care reform has been a major political issue since the early 1990's. Many reports by public or private associations and commissions have discussed restructuring the health care system. Several reports focus on the growing problems of cost and access to care. Some of these reports also link regulation to cost and access issues in terms of its effect on supply, ethnic/racial mix, geographic distribution, efficient use of personnel, horizontal and vertical mobility of the health work force, and innovation in education and utilization of health personnel. (Carpenter, 1993)

There is a lack of uniformity in the terms and definitions employed in state regulatory statutes as well as in private credentialing systems. As a result, considerable confusion surrounds the terminology employed in the regulation of health personnel. (Carpenter, 1993) The recent report of the Task Force on Health Care Workforce Regulation of the Pew Health Professions Commission Points out: *The lack of uniformity in language among the states and the professions limits effective professional practice and mobility, creates barriers to high quality health care, and confuses regulators, legislators, professionals, and the public.* (Pew, 1995)

The report by the Pew Commission recommends that states consider eliminating exclusive scopes of practice which unnecessarily restrict other professions from providing competent, effective and accessible care. The report states, "Scopes of practice' describe the authority vested by a state in health professionals who practice in that state." They draw the boundary between the lay person and the professional; the non-health professional who provides medical services is 'practicing medicine without a license.' Scopes of practice also draw the boundaries among the professions, creating exclusive domains of control over the delivery of specific services. Many professions argue that this exclusivity denies them the right to provide services they are competent to render. The result has been a flood of 'border wars' or 'turf battles' between professions."

"The varying objectives and levels of specificity found in different professions scopes of practice are more than frustrating, they have encouraged a system that treats practice acts as rewards for the professions rather than as rational mechanisms for cost-effective, high-quality and accessible service delivery by competent practitioners. Although couched in consumer protection language, scopes of practice are not always based on the demonstrated ability to provide services that are potentially harmful if not performed competently. Rather, they are written to define differences among professions. Scope of practice battles have come to resemble contests for more patients, more status and power, more independence, and more money. . . Additionally, critics contend that present regulations not only restrict the practice of non-physician practitioners beyond what is justified by skills and training, but grant practice authority to physicians beyond their actual competence." (Pew, 1995)

The report from the Pew Commission articulates the following principles for a health care workforce regulatory system:

- Promoting effective health outcomes and protecting the public from harm
- Holding regulatory bodies accountable to the public;

- Respecting consumers' rights to choose their health care providers from a range of safe options;
- Encouraging a flexible, rational and cost-effective health care system that allows effective working relationships among health care providers; and
- Facilitating professional and geographic mobility of competent providers.

K. Issues Involved in Considering Regulation

The CAM Committee members demonstrated an understanding of the competing interests and tensions involved in the issues of the need and type of regulation necessary or appropriate for CAM occupations and activities. The following information attempts to summarize the constitutional, legal, policy and other considerations touched upon in CAM Committee discussions of recommendations about state regulation of CAM.

1. Constitutional

State regulation of CAM activity will likely deprive some existing practitioners of a continued ability to practice. When attempting to balance the private liberty interest to practice an occupation against the legitimate state interest in protecting the public from harm, the CAM Committee articulated the notion of regulating only those who cause harm or those activities likely to cause harm. Committee members pointed out that many CAM modalities are benign and pose no risk of harm by definition. CAM Committee sentiments against regulating CAM were also expressed in terms of existing licensure regulations which have been and can be used to make the practice of CAM modalities illegal as the unlicensed practice of medicine and to restrict medical licensees from using CAM in conjunction with their authorized practices. Recognition of the power vested in regulatory authorities to prohibit and restrict CAM practice and CAM providers led many CAM Committee members to support recommendations for the least amount of regulation appropriate to protect the public.

2. Legal

CAM Committee members recognized the extent of the current regulatory framework in Minnesota which governs health related occupations. Committee members understood the legal authority vested in licensing boards and Minnesota Department of Health through the numerous practice acts and the statutory provisions of Minn. Stat. Ch. 214. In addition, CAM Committee members quickly recognized the effect that standard setting has in limiting entry to occupational practice, and they understood the uniqueness of the regulatory scheme embodied in the Department of Health's Office of Mental Health Practice. CAM Committee members were therefore hesitant to recommend regulatory schemes like licensure which would likely replicate and multiply existing legal and other problems that CAM providers have pertaining to rights to practice, scope of practice and qualifications to perform activities. Many CAM Committee members expressed an interest in and support for forms of legal protection for both consumers and CAM providers such as an "office of mental health practice"--like authority for CAM healing arts or non-mental health CAM modalities, consumer education and "consumer bill of rights" provisions, and informed consent and medical liability waiver requirements.

3. Policy

CAM Committee members consistently chose to endorse the legislative policies in Minn. Ch. 214 pertaining to occupational regulation. Thus, the recommendations portion of this report begins with "Guiding Principles" that essentially contain a restatement of the twin legislative objectives to regulate foremost to protect the public, and when necessary to regulate, to do so in the least restrictive manner possible. The Guiding Principles also incorporate some of the policy objectives of health care reform legislation enacted in 1992, which emphasize access and cost containment as well as quality of health care providers and services. CAM Committee members appreciated the difficulty in striking balances among competing policy objectives. For example, a lengthy discussion about setting standards for CAM practitioners also recognized that while high standards may assure a level of quality, they would also likely have the effect of increasing consumer costs and reducing consumer access.

4. Other Considerations

CAM Committee members explicitly discussed the question of whether it was appropriate to recommend regulation of specific CAM occupations such as naturopathy and massage therapy. Significantly, the consensus of the Committee was that there had not been time to competently review and consider the factual information and issues for each occupation. Thus, the CAM Committee recommended that this be addressed in the future, that the Committee continue to meet and that Minnesota Department of Health be funded to do further research and staff the CAM Committee meetings.

PART VIII: SUMMARY AND CONCLUSION

The issues surrounding the wide variety of therapies and techniques of complementary and alternative medicine are very complex. The availability and utilization of complementary and alternative medicine in the current health care market has very far-reaching implications. As this report has indicated, consumers across the United States are using complementary and alternative forms of therapy. However, we know little about the safety and efficacy of many modalities. Governmental regulation of any of the types of therapy is not recommended at this time. Further consideration and discussion by consumers, CAM providers, and health care organizations of the need for and type of regulation is required.

The information provided in this report is of a general, background nature. There are many areas that require further study and research in order to more fully explore the implications of the presence and utilization of complementary and alternative medicine in the health care market in Minnesota. We hope that this report will provide the groundwork for further analysis and study of these complex issues.

BIBLIOGRAPHY

- Abu-Realh, M.H., Magwood, G., et al. "The Use of Complementary Therapies by Cancer Patients." *NursingConnections*. 9, 4 (1996):3-12.
- Academic Health Center Task Force on Complementary Care - University of Minnesota. "Transforming Health Care: Integrating Complementary, Spiritual and Cross-Cultural Care." (1997):2-21.
- Adikwu, M.U. "Could the Law Governing the use of 'Prescription-only' Medicines be Extended to Traditional Medicines." *Tropical Doctor*. July (1992):122.
- Akerele, O., M.D. "Towards the Utilization of Traditional Medicine in National Health Services." *American Journal of Chinese Medicine*. XIV, 1-2 (1986):2-10.
- Allina Health System. "Has Traditional Medicine Gone Quackers?" *Allina Today*. 1, 6 (1996):1-5.
- Alternative Therapies in Health and Medicine. "Access to Medical Treatment Act Stalled in Senate and House Subcommittees." *Alternative Therapies in Health and Medicine*. 2, 4 (1996):34.
- Amar, P.B. "Biofeedback and Applied Psychophysiology at the Crossroads." *Biofeedback and Self-Regulation*. 18, 4 (1993):201-209.
- American Holistic Nurses Association. "Personal Correspondence with the American Holistic Nurses Association." (1997).
- Amoils, S., M.D., Korte, D., et al. "Correspondence: Unconventional Medicine." *The New England Journal of Medicine*. 329, 16 (1993):1200-1204.
- Angier, N. "U.S. Opens the Door Just a Crack to Alternative Forms of Medicine." *New York Times*. January 10, 1993.
- Baar, K. "The Real Option in Healthcare." *Natural Health*. November/December (1994):94-105.
- Barlow, J.F., M.D. "Freedom of Choice in Medicine - "It Makes Me Feel Better"." *South Dakota Journal of Medicine*. 45, 5 (1992):125.
- Barrett, S., M.D. "The Public Needs Protection From So-Called 'Alternatives'." *The Internist*. 35, 8 (1994):10-11.
- Beck, R.L., J.D. "An Overview of State Alternative Healing Practices Law." *Alternative Therapies*. 2, 1 (1996):31-33.

Berlin, B., Ph.D. "Traveling Down a Different Path: Alternative Medicine." *New Jersey Medicine*. 94, 4 (1997):35-37.

Black, D., Ph.D. *Health at the Crossroads*. Springville, UT: Tapestry Press, 1988.

Booth, B. "Naturopathy." *Nursing Times*. 90, 7 (1994):44-46.

Boozang, K.M. "Developing Public Policy for Sectarian Providers: Accommodating Religious Beliefs and Obtaining Access to Care." *Journal of Law, Medicine & Ethics*. 24(1996):90-98.

Borkan, J., M.D., Ph.D., Neher, J.O., M.D., et al. "Referrals for Alternative Therapies." *The Journal of Family Practice*. 39, 6 (1994):545-550.

Brewin, T.B. "'Orthodox' and 'Alternative' Medicine." *Scottish Medical Journal*. 30, 4 (1985):203-205.

Brown, P., M.D. "Chiropractic: A Medical Perspective." *Minnesota Medicine*. 77, February (1994):21-25.

Bruder, P. "'Gotcha Covered': Puzzling Out the Mysteries of Health Insurance Benefits Coverage." *Hospital Topics*. 71, 4 (1993):8-10.

Burri, M., M.A. "Med Chi vs the Thomsonians: A Legislative Vignette." *Maryland Medical Journal*. 45, 2 (1996):127-128.

Cairney, P. "Alternative Medicine." *New Zealand Medical Journal*. March (1989):143-144.

Callahan, S., Ph.D. "Ethical Issues of Unconventional Therapies." *Health Progress*. 74, 7 (1993):42-43.

Campion, E.W., M.D. "Why Unconventional Medicine?" *The New England Journal of Medicine*. 328, 4 (1993):282-283.

Canosa, J.F. and Lewandowski, L.M. "Linking Individual and Organizational Wellness." *Health Progress*. 74, 7 (1993):44-47.

Capen, K. "Courts, Licensing Bodies Turning Their Attention to Alternative Therapies." *Canadian Medical Association Journal*. 156, 9 (1997):1307-1308.

Caplan, R.L., Ph.D. "Chiropractic in the United States and the Changing Health Care Environment: A View from Outside the Profession." *Journal of Manipulative and Physiological Therapeutics*. 14, 1 (1991):46-50.

Carpenter, E. "Licensing and Credentialing in the Health Care Industry." #96-3(1993):1-37.

Carper, J. "Nature's Healing Power." *USA Weekend*. July 11-13(1997):4-6.

- Carroll, D. "Self-Help and the New Health Agenda." *Social Policy*. Spring (1994):44-52.
- Cassidy, C.M. "Cultural Context of Complementary and Alternative Medicine Systems. In: *Fundamentals of Complementary and Alternative Medicine*. Edited by Micozzi, M.S. New York, NY: Churchill Livingstone, 1996, p.9.
- Center for Addiction and Alternative Medicine Research. "Opinions About Alternative Medicine in Minnesota's Health Care Marketplace." (1996).
- Chowka, P.B. "*What is Naturopathic Medicine? The History and Practice in North America. (Internet)*." 1996.
- Chung, M.K., M.D. "Why Alternative Medicine?" *American Family Physician*. 54, 7 (1996):2184-2187.
- Cleaveland, M.J., M.S. and Biester, D.J., Ph.D. "Alternative and Complementary Therapies: Considerations for Nursing Practice." *Journal of Pediatric Nursing*. 10, 2 (1995):121-123.
- Coalition for Natural Health. "*What is a Traditional Naturopath? (Internet)*." 1997.
- Cohen, M.H. "A Fixed Star in Health Care Reform: The Emerging Paradigm of Holistic Healing." *Arizona State Law Review*. Spring (1995):79-172.
- Cohen, M.H. "Guaranteeing Freedom of Access to Healing - The Access to Medical Treatment Act of 1995." *Alternative and Complementary Therapies*. November/December (1995):408-410.
- Cohen, M.H. "Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes." *Arizona Law Review*. 38, 83 (1996):83-164.
- Coiles, R. "Chiropractic Treatment." *Health Trends*. 7, 9 (1995):1,3,6-7.
- Colgate, M.A. "Gaining Insurance Coverage for Alternative Therapies." *Journal of Health Care Marketing*. 15, 1 (1995):24-28.
- Consumer Reports. "Alternative Medicine: The Facts." *Consumer Reports*. 59, 1 (1994):51-59.
- Consumer Reports. "Chiropractors." *Consumer Reports*. 59, 6 (1994):383-390.
- Consumer Reports. "Homeopathy - Much Ado About Nothing?" *Consumer Reports*. 59, 3 (1994):201-207.
- Cooper, R. and Stoflet, S.J. "Trends in the Education and Practice of Alternative Medicine Clinicians." *Health Affairs*. 15, 3 (1996):226-238.
- Coulter, H.L., Ph.D. "Alternative Medicine: A Challenge to Federal and State Regulators." (1997).

Cox, S. and Foster, S. "The Costs and Benefits of Occupational Regulation." (1990).

Craig, R.H., Jr., Rothenberger, J.L., and Light, L.L. "Legislature Ends 1985-86 Session in Wee Hours." *Pennsylvania Medicine*. January (1987):17-18.

Crellin, J.K., M.D., Ph.D. "Should Homeopathy Be Reconsidered?" *North Carolina Medical Journal*. 48, 9 (1987):447-450.

Crowe, B.J., R.M.T.-B.C. "Music Therapy Credentials." *Journal of Psychosocial Nursing and Mental Health Services*. 31, 1 (1993):4.

Davis, E.R. "Personal Correspondence with Edith R. Davis." (1997).

Davis, E.H., M.D. "Complementary or Alternative Medicine." *Journal of American Board of Family Practice*. 9, 1 (1996):70.

Davis, E.H., M.D. and Brown, P., M.D. "Different Viewpoints on Alternative Medicine." *American Family Physician*. 55, 6 (1997):2079-2080.

Department of Health and Mental Hygiene - State of Maryland. "Final Report, State Commission on Complementary Medical Methods." (1995):1-5.

De Smet, P.A.G.M. "Should Herbal Medicine-like Products be Licensed as Medicines." *British Medical Journal*. 310, April (1995):1023-1024.

DeFazio, P. "Why It's Time for the Access to Medical Treatment Act." *Alternative Therapies*. 2, 1 (1996):94.

Dolamore, M.J., M.D. "Alternative Medical Therapies." *Archives of Family Medicine*. 4, January (1995):17-18.

Drane, J.F. "Alternative Therapies II: Ethical and Legal Issues." *Encyclopedia of Bioethics*. (1997):135-143.

Drew, A.K. and Myers, S.P. "Safety Issues in Herbal Medicine: Implications for the Health Professions." *Medical Journal of Australia*. 166, 10 (1997):538-541.

Dumoff, A. "Including Alternative Providers in Managed Care - Managing the Malpractice Risk: Part 1." *Medical Interface*. May (1995):95-102.

Dumoff, A. "Including Alternative Providers in Managed Care - Managing the Malpractice Risk: Part 2." *Medical Interface*. June (1995):127-132.

Dumoff, A. "Malpractice Liability of Alternative/Complementary Health Care Providers: A View From the Trenches. (Internet)." (1997).

Dumoff, A., J.D. "Protecting Your Practice - Myth Vs. Fact." *Alternative and Complementary Therapies*. May/June (1996):186-190.

Dumoff, A., J.D. "Understanding the Kassebaum-Kennedy Health Care Act - Addressing Legitimate Concerns and Irrational Fears." *Alternative and Complementary Therapies*. August (1997):309-313.

Dunea, G., M.D. "Letter from ...Chicago." *British Medical Journal*. 296, January (1988):277-278.

Eckman, J. "Homeopathic and Eclectic Medicine in Minnesota." *Minnesota Medicine*. June-December (1941).

Eisenberg, D.M., M.D., Kessler, R.C., Ph.D., et al. "Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use." *The New England Journal of Medicine*. 328, January (1993):246-252.

Eisenberg, D.M., M.D. "Advising Patients Who Seek Alternative Medical Therapies." *Annals of Internal Medicine*. 127, 1 (1997):61-69.

Elder, N.C., M.D., Gillcrist, A., M.D., and Minz, R., M.D. "Use of Alternative Health Care by Family Practice Patients." *Archives of Family Medicine*. 6, March/April (1997):181-184.

Ernst, E. "Complementary Medicine. Who Prescribes These Treatments and When?" *British Medical Journal*. 307, July (1993):326.

Ernst, E., Baldry, P., et al. "Complementary Medicine." *The Lancet*. 307, May (1993):326-327.

Ernst, E. and Abbot, N.C. "Research Priorities in Complementary Medicine." *British Medical Journal*. Spring (1996):1005-1006.

Ferguson, J.H., M.D., Dubinsky, M., Ph.D., and Kirsch, P.J., J.D. "Court-Ordered Reimbursement for Unproven Medical Technology." *Journal of the American Medical Association*. 269, 16 (1993):2116-2121.

Firshein, J. "Picture Alternative Medicine in the Mainstream." *Business & Health*. April (1995):29-33.

Fisk, W. "Multiculturalism, Alternative Health Care, and Responsibility for Belief." *The Mount Sinai Journal of Medicine*. 62, 2 (1995):148-151.

Fletcher, D.M. "Unconventional Cancer Treatments: Professional, Legal, and Ethical Issues." *Oncology Nursing Forum*. 19, 9 (1992):1351-1354.

Freer, C.B. "What Kind of Alternative is Alternative Medicine?" *Journal of the Royal College of General Practitioners*. 35 (1985):459-461.

- Garvin, M.L., S.S.J., Heib, M., R.S.M., and Owens, H., O.S.F. "Holistic Retreats." *Health Progress*. 74, 7 (1993):51-65.
- Gelber, B.R., M.D. "What Are the Standards?" *Nebraska Medical Journal*. 73, 4 (1988):82.
- Gervais, K.G., Ph.D. "Providing Culturally Competent Health Care to Hmong Patients." *Minnesota Medicine*. 79, May (1996):49-51.
- Gilmore, D.A., J.D. "The Antitrust Implications of Boycotts by Health Care Professionals: Professional Standards, Professional Ethics and The First Amendment." *American Journal of Law & Medicine*. XIV, 2-3 (1988):221-248.
- Goch, L. "Alternative Medicine Moves Into the Mainstream." *Best's Review*. March (1997):84-88.
- Goodliffe, H. "Therapies Under Threat." *Nursing Times*. 86, 26 (1990):48-49.
- Gordon, J.S., M.D. "Alternative Medicine and the Family Physician." *American Family Physician*. 54, 7 (1996):2205-2212.
- Gordon, J., M.D. "Changing How We Define Medicine. (Internet)." (1997).
- Gorski, T., M.D. and Dyer, K.A., M.D. "Defining and Assessing Alternative Medicine Practices." *Journal of the American Medical Association*. 276, 3 (1996):195-196.
- Granju, K. "The Trials of the Midwife." *Minnesota Parent*. 12, 132 (1997):10-11, 13-16.
- Green, J.A., J.D. "Integrating Conventional Medicine and Alternative Therapies." *Alternative Therapies*. 2, 4 (1996):77-81.
- Hadlow, V. "Alternative Medicine." *New Zealand Medical Journal*. January (1989):21.
- Hamilton, D., R.D. and Bechtel, G.A., R.N. "Research Implications for Alternative Health Therapies." *Nursing Forum*. 31, 1(1996):6-10.
- Health World Online. "Professional Associations Online. (Internet)." (1997).
- Healy, H., N.D. "Personal Correspondence with Helen Healy, N.D." (1997).
- Himmel, W., Schulte, M., and Kochen, M.M. "Complementary Medicine: Are Patients' Expectations Being Met by Their General Practitioners?" *British Journal of General Practice*. 43, June (1993):232-235.
- Humphrey, H.H., III. "Alternative Health Care." (1997).
- Issel, C., M.A. "Legislation Versus Self-Regulation in the Somatic Practices Field." *Alternative and Complementary Therapies*. June (1997):217.

- Ivey, T.L., D.C., Homola, S., D.C., et al. "Chiropractic Scope of Practice." *Journal of Manipulative and Physiological Therapeutics*. 17, 3 (1994):202-203.
- Jarvis, W.T., Ph.D. "Allergy-related Quackery." *New York State Journal of Medicine*. 93, 2 (1993):100-104.
- Johnson, I.S. and St. George, D. "Complementary Medicine." *British Medical Journal*. 307, September (1993):624.
- Johnson, J. "Personal Correspondence with Jerri Johnson, Minnesota Natural Health Coalition." (1997).
- Jonas, W.B., M.D. "Alternative Medicine: An Overview." *Caring Magazine*. , December (1996):16-18.
- Justice, B., Ph.D. "Alternative Medicine's Relevance to Public Health Practice and Research." *Alternative Therapies*. 2, 3 (1996):24-25.
- Kaptchuk, T.J., Kristoffersen, S.S., et al. "Uptake of Alternative Medicine." *The Lancet*. 347, April (1996):972-973.
- Kaul, P.N. "Alternative Therapeutic Modalities. Alternative Medicine." *Progress in Drug Research*. 47(1996):251-277.
- Kelner, M., Ph.D. "Who Seeks Alternative Health Care? A Profile of the Users of Five Modes of Treatment." *The Journal of Alternative and Complementary Medicine*. Summer (1997):10.
- Kennedy, M. "Natural-Borne Healers." *Wisconsin Medical Journal*. 96, 3 (1997):21-27.
- Kleijnen, J., Knipschild, P., and ter Riet, G. "Clinical Trials of Homeopathy." *British Medical Journal*. 302(1991):316-323.
- Kottow, M.H. "Classical Medicine v Alternative Medical Practices." *Journal of Medical Ethics*. 18(1992):18-22.
- Kushner, T. and Mackay, C. "Joseph J. Jacobs on Alternative Medicine and the National Institutes of Health." *Cambridge Quarterly of Healthcare Ethics*. 3(1994):442-448.
- Ladwig, S.J. "State Massage Therapy Laws." (1997).
- Lamm, L.C., D.C., Wegner, E., and Collord, D. "Chiropractic Scope of Practice: What the Law Allows - Update 1993." *Journal of Manipulative and Physiological Therapeutics*. 18, 1 (1995):16-20.
- Langone, J. "Challenging the Mainstream." *Time*. 148, 14 (1996):40-43.

- Lay, B.F. "Healer-Patient Privilege: Extending the Physician-Patient Privilege to Alternative Health Practitioners in California." *Hastings Law Journal*. 48(1997):633-666.
- Loue, S., J.D. "Access to Health Care and the Undocumented Alien." *The Journal of Legal Medicine*. 13(1992):271-332.
- Lowe, R. "Personal Interview with Dr. Michele Strachan and Ahmad Azzahir. The Powderhorn/Phillips Cultural Wellness and Health Education Center." (1997).
- Manka, A.K. "Legal Issues Associated with the Practice of Complementary Medicine." (1997).
- Markoff, N. and Duffy, P. *Why I Survive Aids*. New York, NY: Simon and Schuster, 1991.
- Maxwell, R.J. "The Osteopaths Bill." *British Medical Journal*. 306, June (1993):1556-1557.
- McCormick, G.M. "Statutory Criteria for Regulating Occupations." (1997).
- Melchart, D., M.D., Linde, K., M.D., et al. "Systematic Clinical Auditing in Complementary Medicine: Rationale, Concept, and a Pilot Study." *Alternative Therapies*. 3, 1 (1997):33-38.
- Meyer, C.R. "The Psychology of Wellness - Blending Biomedicine, Belief, and Alternative Care." *Minnesota Medicine*. 79, December (1996):29-30.
- Micozzi, M.S. "The Need to Teach Alternative Medicine." *Caring Magazine*. , December (1996):20-22.
- Minnesota Chiropractic Association. "Correspondence with Minnesota Chiropractic Association." (1997).
- Moffet, H.H., M.S. "Alternative Medicine and Managed Care: Are We Making Any Progress?" *Alternative and Complementary Therapies*. 1(1994):14-16.
- Montbriand, M.J. "Freedom of Choice: An Issue Concerning Alternate Therapies Chosen by Patients with Cancer." *Oncology Nursing Forum*. 20, 8 (1993):1195-1201.
- Moore, N.G. "A Review of Reimbursement Policies for Alternative and Complementary Therapies." *Alternative Therapies*. 3, 1 (1997):26-92.
- Mootz, R.D., D.C., Hess, J.A., D.C., and McMillin, A.D., D.C. "Resource-Based Relative Value Scales: Impacts and Recommendations Relative to Chiropractic Practice." *Journal of Manipulative and Physiological Therapeutics*. 18, 5 (1995):271-284.
- Mootz, R.D., D.C. "The Impact of Health Policy on Chiropractic." *Journal of Manipulative and Physiological Therapeutics*. 19, 4 (1996):257-264.
- Moser, K.M. "The "Alternative Therapy" Controversy: Facts Are Needed." *Heart & Lung The Journal of Critical Care*. 11, 3 (1982):195-196.

- Moulds, R.F.W. and McNeil, J.J. "Herbal Preparations - To Regulate or Not To Regulate." *The Medical Journal of Australia*. 149, December (1988):572-574.
- Murata, S. "Uncle Sam Gets Serious About Alternative Medicine." *Medical Economics*. 71, 2 (1994):100-109.
- Murray, R.H., M.D. and Rubel, A.J., Ph.D. "Physicians and Healers - Unwitting Partners in Health Care." *The New England Journal of Medicine*. 326, 1 (1992):61-64.
- National Center for Homeopathy. "Professional Training in Homeopathy." (1997).
- National Council Against Health Fraud. "Acupuncture: The Position Paper of the National Council Against Health Fraud." *The Clinical Journal of Pain*. 7, 2 (1991):162-166.
- National Institutes of Health. "Alternative Medicine: Expanding Medical Horizons." (1992):1-372.
- National Research Corporation. "Executive Summary from the Abbott Northwestern Hospital Consumer Study." (1995).
- OAM Panel on Definition and Description - CAM Research Methodology Conference April 1995. "Defining and Describing Complementary and Alternative Medicine." *Alternative Therapies*. 3, 2 (1997):49-57.
- Orr, R.D., M.D., Marshall, P.A., Ph.D., and Osborn, J., M.D. "Cross-cultural Considerations in Clinical Ethics Consultations." *Archives of Family Medicine*. 4, 2 (1995):159-164.
- Pal, B., Engehaugen, K., and Sorlie, K.B. "Complementary Medicine." *British Medical Journal*. 313, October (1996):1080-1081.
- Paramore, C., M.S.P.H. "Use of Alternative Therapies: Estimates from The 1994 Robert Wood Johnson Foundation National Access to Care Survey." *Journal of Pain and Symptom Management*. 13, 2 (1997):83-89.
- Patankar, S.K., M.D., Ferrara, A., M.D., et al. "Biofeedback in Colorectal Practice: A Multicenter, Statewide, Three-Year Experience." *Diseases of the Colon and Rectum*. 40, (7) (1997):827-831.
- Patel, M.S. "Problems in the Evaluation of Alternative Medicine." *Social Science and Medicine*. 25, 6 (1987):669-678.
- Paterson, C. "Complementary Medicine." *British Journal of General Practice*. July (1996):440.
- Pearson, H. "Editorial: The Need to Liberate Physicians to Practice Complementary Medicine. (Internet)." *Journal of Orthomolecular Medicine*. 10, 3, 4 (1995).

Pew Health Professions Commission. "Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century." (1995):1-47.

Pietroni, P.C., M.R.C.P. "Alternative Medicine." *The Practitioner*. 230, December (1986):1053-1054.

Pietroni, P.C. "Alternative Medicine: Methinks the Doctor Protests Too Much and Incidentally Befuddles the Debate." *Journal of Medical Ethics*. 18, 1 (1992):23-25.

Pietroni, P.C., F.R.C.G.P. "The Interface Between Complementary Medicine and General Practice." *Journal of the Royal Society of Medicine*. 87, Supplement 22 (1994):28-30.

Poole, S.R., M.D. and Anstett, R.E., M.D., Ph.D. "Patients Who Request Alternative (Non-medical) Health Care." *The Journal of Family Practice*. 16, 4 (1983):767-772.

Rankin-Box, D. "Proceed With Caution." *Nursing Times*. 87, 45 (1991):34-36.

Rankin-Box, D. "Complementary Therapies in 1992." *Nursing*. 4, 47 (1992):27-28.

Read, J.O. "Complementary Care: A Healing Approach." *University of Minnesota Medical Bulletin*. Summer (1997):10-15.

Redwood, D., D.C. "Interview with Marc Micozzi, M.D., Ph.D. (Internet)." (1995).

Redwood, D., D.C. "James Gordon, M.D. Manifesto for a New Medicine (Internet)." (1996).

Riessman, F. "Alternative Health Movements." *Social Policy*. Spring (1994):53-57.

Robbins, J. *Reclaiming Our Health*. Tiburon, CA: H.J. Kramer, 1996.

Rossmann, M.L., M.D. and Benjamin, S., M.D. "Managed Care and Alternative Medicine: Who Will Manage What, and How? Carefully Embracing Managed Care." *Alternative Therapies*. 3, 3 (1997):63-68.

Sale, D.M., J.D. "Overview of Legislative Development Concerning Alternative Health Care in the United States. (Internet)." (1994).

Schneider, J. "Wants To See Public Health Departments Incorporate Alternative Therapies." *Alternative Therapies*. 2, 1 (1996):14.

Seidl, L.G. "The Value of Spiritual Health." *Health Progress*. 74, 7 (1993):48-50.

Shaw, D., Kolev, S., et al. "Should Herbal Medicines be Licensed?" *British Medical Journal*. 311, August (1995):451-452.

Shepherd, S. "Alternative Medicine." *The Lancet*. August (1996):346-347.

Shimberg, B. and Roederer, D. "Occupational Licensing: Questions a Legislator Should Ask." (1978):1.

Smith, D.L., M.D. "Alternative Therapies." *The Journal of Family Practice*. 40, 6 (1995):535.

Smith, M.M., D.C. "Chiropractic Research: The Ethics." *Journal of Manipulative and Physiological Therapeutics*. 15, 8 (1992):536-541.

Spencer, M.H. "Physicians Should Keep an Open Mind on Complementary Health Care, Congress Says." *Canadian Medical Association Journal*. 153, 12 (1995):1796-1797.

State Laws. "State Laws Accommodating the Use of Alternative Health Care Therapies by Physicians (Internet)." (1997).

Stevensen, C., B.S.W. "Complementary Therapies and Their Role in Nursing Care." *Nursing Standard*. 11, 24 (1997):49-53.

Stratton, W.T., J.D. "Is a Chiropractor a Physician?" *Kansas Medicine*. January (1993):8.

Sugerman, D. "Healing Body and Spirit." *Minnesota Medicine*. 79(1996):8-9-44-45.

Thurtle, V., R.G.N. "Viable Alternative." *Nursing Standard*. 8, 24 (1994):52-53.

Tiran, M.D., S.R.N. "Complementary Medicine and Midwifery." *Midwives Chronicle & Nursing Notes*. 101, 1204 (1988):139-142.

Trevelyan, J. and Booth, B. "Herbalism: Useful Remedies." *Nursing Times*. 91, 45 (1995):45-46.

Trevelyan, J. "Unfairly Condemned?" *Nursing Times*. 86, 26 (1990):50-51.

Trevelyan, J. "Acupuncture." *Nursing Times*. 89, 28 (1993):26-28.

Trevelyan, J. "The New Fringe?" *Nursing Times*. 91, 11 (1995):26-28.

Tyson, J. "The Boundary Between Therapeutic and Non-Therapeutic Research: Dubious Distinctions Between Research and Clinical Practice Using Experimental Therapies: Have Patients Been Well Served?" *Ethics and Perinatology*. (1995):214-230.

Tyson, J.E. "Use of Unproven Therapies in Clinical Practice and Research: How Can We Better Service Our Patients and Their Families." *Seminars in Perinatology*. 19, 2 (1995):98-111.

Van Horn, J. "Personal Correspondence with James Van Horn." (1997).

Verhoef, M.J., M.Sc., Sutherland, L.R., M.D., and Brkich, L., LL.B. "Use of Alternative Medicine by Patients Attending a Gastroenterology Clinic." *Canadian Medical Association Journal*. 142, 2 (1990):121-125.

Vickers, A., Phillips, K.D., et al. "Regulating Complementary Medicine." *British Medical Journal*. 313, October (1996):881-882.

Vickers, A., Cassileth, B., et al. "How Should We Research Unconventional Therapies? A Panel Report from the Conference on Complementary and Alternative Medicine Research Methodology, National Institutes of Health." *International Journal of Technology Assessment in Health Care*. 13, 1 (1997):111-121.

Villaire, M. "Update on Minneapolis, Seattle Alternative Medicine Research Centers." *Alternative Therapies*. 2, 4 (1996):25-26.

Wahlqvist, M.L., Clark, A.C.L., et al. "Alternative Medicine." *Medical Journal of Australia*. 143, 4 (1985):152.

Weiler, K. "Legal Risks of Nontraditional Nursing Care." *Journal of Gerontological Nursing*. 19, 4 (1993):47.

Wood, M. *A History of Herbalism in Minnesota*. 1997.

Wood, P.H.N. and Williams, G.H. "The Attraction of Alternative Therapies." *Ethical Dilemmas in Cancer Care*. (1989):117-125.

Yeolekar, M.E. "Complementary Medicine: A Different Dimension." *Journal of Laboratory and Clinical Medicine*. 129, 2 (1997):266.

Young, S.D. "The Rule of Experts: Occupational Licensing in America." (1987).

Appendix A

APPENDIX A

Laws of Minnesota 1997, Chapter 203, Article 1, Section 3, Subd. 2

[COMPLEMENTARY MEDICINE STUDY.] (a) Of the general fund appropriation, \$20,000 in fiscal year 1998 shall be disbursed for the Commissioner of Health, in consultation with the Commissioner of Commerce, to conduct a study based on existing literature, information, and data on the scope of complementary medicine offered in this state. The commissioner shall:

- (1) Include the types of complementary medicine therapies available in this state;
- (2) Contact national and state complementary medicine associations for literature, information, and data;
- 3) Conduct a general literary review for information and data on complementary medicine;
- (4) Contact the departments of commerce and human services for information on existing registrations, licenses, certificates, credentials, policies, and regulations; and
- (5) Determine by sample, if complementary medicine is currently covered by health plan companies and the extent of the coverage. In conducting this review, the commissioner shall consult with the office of alternative medicine through the National Institute of Health.
 - (b) The commissioner shall, in consultation with the advisory committee, report the study findings to the legislature by January 15, 1998. As part of the report, the commissioner shall make recommendations on whether the state should credential or regulate any of the complementary medicine providers.
 - (c) The commissioner shall appoint an advisory committee to provide expertise and advice on the study. The committee must include representation from the following groups: health care providers, including providers of complementary medicine; health plan companies; and consumers. The advisory committee is governed by Minnesota Statutes, section 15.059, for membership terms and removal of members.
 - (d) For purposes of this study, the term "complementary medicine" includes, but is not limited to, acupuncture, homeopathy, manual healing, macrobiotics, naturopathy, biofeedback, mind/body control therapies, traditional and ethnomedicine therapies, structural manipulations and energetic therapies, bioelectromagnetic therapies, and herbal medicine.

Appendix B

APPENDIX B

**Complementary Medicine Advisory Committee
Minnesota Department of Health
Health Economics Program
Fall 1997**

The Honorable Linda Berglin
The Honorable Janet Johnson
Gayle Burdick, American Massage Therapy Association, Minnesota Chapter
Andrea Childs, Consumer Representative
Patricia Culliton, Center for Addiction and Alternative Medicine Research, HCMC
Janet Dahlem, College of St. Catherine Holistic Therapies Program
Connie DeLorme, Consumer Representative
Gail Ehlen, Medica Health Plans
Gwen Halaas, HealthPartners
Helen Healy, Association of Naturopathic Physicians
Todd Holmes, Allina Health System
Jerri Johnson, Minnesota Natural Health Coalition
Karen Kiemele, Blue Cross Blue Shield of Minnesota
Mary Jo Kreizer, University of Minnesota, Center for Spirituality and Healing
Harlan Mittag, Board of Infinite Health Provider Network
Erin Murphy, Minnesota Nurses Association
Paul Sanders, Minnesota Medical Association
John Staba, University of Minnesota, Emeritus of Pharmacognosy/Medicinal Chemistry
Michele Strachan, Powderhorn/Phillips Cultural Wellness and Health Education Center
Carolyn Torkelson, Park Nicollet Office of Complementary Medicine
Beverly Turner, Insurance Federation of Minnesota
James VanHorn, Christian Science, Prayer Therapy

Appendix C

APPENDIX C

Complementary/ Alternative Medicine Therapies

A Partial Alphabetical Listing

Acupressure: Similar to acupuncture, acupressure is based on the principle that the body contains energy channels or meridians through which flows a vital life energy or "qi." Unlike acupuncture however, acupressure does not involve the use of needles to stimulate energy points along the meridians, but employs pressure from the fingers and hands for the same purpose. In stimulating the energy points in this way, acupressure aims to remove energy blocks which produce health problems. Acupressure is generally treated as an adjunct therapy to either acupuncture or massage. (Sale, 1994)

Acupuncture: This involves stimulating specific anatomic points in the body for therapeutic purposes. Puncturing the skin with a needle is the usual method, but practitioners also use heat, pressure, friction, suction, or impulses of electromagnetic energy to stimulate the points. In the past 40 years acupuncture has become a well-known, reasonably available treatment in developed and developing countries. Acupuncture is used to regulate or correct the flow of qi in order to restore health. Modern theories of acupuncture are based on laboratory research conducted in the past 40 years. Acupuncture points have certain electrical properties, and stimulating these points alters the neurotransmitters in the body. The physiologic effects of acupuncture stimulation in experimental animals have been well documented, and in the past 20 years acupuncture has become an increasingly established health care practice. An estimated 3,000 conventionally trained U.S. physicians have taken courses to incorporate acupuncture in their medical practices. (NIH, 1992)

Alexander Technique: The Alexander technique is predicated on the connection between serious physical problems and faulty posture in sitting, standing and moving. Through awareness, movement, and touch, the modality aims to interrupt habitual patterns of posture, restore the correct relationship of head, neck, and back in order to promote proper balance, posture, and movement in the body. In addition, the Alexander Technique seeks to improve conditions of disease that have been adversely affected by faulty physical use of the body. (Sale, 1994)

Anthroposophically Extended Medicine: This is an extension of Western biomedicine and also incorporates approaches and therapeutics from naturopathy and homeopathy. There are an estimated 30 to 100 physicians in the United States who practice anthroposophical medicine. Hundreds of uniquely formulated medications are used in anthroposophical practice. Each medicine is used to match the key dynamic forces in plants, animals, and minerals with disease processes in humans to stimulate healing. Much of the research in anthroposophically extended medicine has been connected with attempts to understand the nature of disease, assess treatments qualitatively, and understand how the essential properties of the objects under investigation could be applied in therapy. (NIH, 1992)

Aromatherapy: Aromatherapy utilizes the medicinal properties of essential oils extracted from plants and herbs through a process of steam distillation or cold pressing. Treatments may be administered through inhalation, external application (e.g., bath, massage, compress, or topically), or by ingestion. Essential oils are believed to act on the adrenals, ovaries and the thyroid and to energize or pacify, detoxify and facilitate the digestive process. (Sale, 1994)

Art Therapy: A means for the patient to reconcile emotional conflicts, foster self-awareness, and express unspoken and frequently unconscious concerns about his/her disease. In addition to its use in treatment, it can be used to assess individuals, couples, families, and groups. It is particularly valuable with children who often cannot talk about their real concerns. (NIH, 1992)

Ayurveda: This word is derived from the Sanskrit words 'Ayur' meaning life and 'Veda' meaning knowledge. It is the art and science of the holistic system of medicine practiced in India since 8000 B.C. The oldest system of medicine known to humanity, ayurveda is recognized by the World Health Organization and is practiced around the world. In India, there are over 300,000 practicing ayurvedic physicians and over 100 ayurvedic colleges providing a five-year degree program. There are 10 Ayurveda clinics in North America, including one hospital-based clinic that has served 25,000 patients since 1985. Ayurveda emphasizes a balanced harmony between the mind, the body and the spirit. The diagnosis of ill-health is based on the concept that all people belong to three metabolic types known in Sanskrit as 'Vata,' 'Pitta' and 'Kapha.' By approximation, the three types can be compared to the body types thin, muscular and fat. The diagnosis of the 'tridosha' body type uses the quality of the pulse and its rate, the texture of tongue, the appearance of nails and skin, and urinalysis. Once the mind-body-spirit imbalance (disease) is diagnosed, the treatment may call for 'shodan' (cleansing and detoxication), or 'shaman' (palliation), or 'rasayana' (rejuvenation), and/or 'satvajaya' (mental and spiritual hygiene). The cleansing and detoxication involves a process of rinsing and purging the stomach by emesis, the bowels by purgatives and oil lavage, the rectum by enema, the blood by herbal tonics, and the nasal passage by douching. These five procedures together are known as 'panchakarma.' The palliative treatment, 'shaman,' is usually a combination of the use of herbs, fasting, chanting of certain words or phrases repeatedly, deep breathing, physical exercises, and meditation. This treatment may be prescribed to a patient that is either too weak or too ill to withstand the more aggressive 'panchakarma'. By using ayurvedic herbal products in the form of pills, powders, jellies, jams. etc., overall vitality and the immune system of the body are strengthened. (Kaul, 1996)

Bioelectromagnetics: This uses electromagnetic fields as a form of healing. Electrical phenomena are found in all living organisms, and electrical currents in the body can produce magnetic fields that extend outside the body. These fields from the body can be influenced by external magnetic and electromagnetic fields. Changes in the body's natural fields may produce physical and behavioral changes. This category of CAM systems include the following modalities: BlueLight Treatment and Artificial Lighting, Electroacupuncture, Electromagnetic Fields, Electrostimulation and Neuromagnetic Stimulation Devices, and Magneto-resonance Spectroscopy. Major new applications of nonthermal, nonionizing electromagnetic fields include: bone repair, nerve stimulation, wound healing, treatment of osteoarthritis, electroacupuncture, tissue regeneration, and immune system stimulation. (NIH, 1992)

Biofeedback: A treatment method that uses monitoring instruments to provide patients with physiological information, of which they are normally unaware. By watching the monitoring device, patients can learn to adjust their thinking and other mental processes in order to control bodily processes. It is used to treat a wide variety of conditions and diseases, ranging from stress, alcohol and other addictions, sleep disorders, epilepsy, respiratory problems, and fecal and urinary incontinence to muscle spasms, partial paralysis, or muscle dysfunction caused by injury, migraine headaches, hypertension, and variety of vascular disorders. (NIH, 1992) The Health Care Financing Administration defines biofeedback as a therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone or light, the loudness or brightness of which shows the extent of activity in the function being measured. (Sale, 1994)

Biofield Therapeutics: A Treatment also referred to as the laying on of hands, is a very old form of healing. The philosophy focuses on two views. First, the healing force comes from God, the cosmos, or another supernatural entity. Second, the operative mechanism is the human biofield, which is directed, modified, or amplified in some way by the practitioner. (NIH, 1992.) During biofield treatment, the practitioner places hands directly on or near the patient's body to improve general health or treat a specific dysfunction. Treatment sessions may take from 20 minutes to an hour or more; a series of sessions is often needed to treat some disorders. There is consensus among practitioners that the biofield permeates the physical body and extends outward for several inches. Extension of the external biofield depends on the person's emotional state and health. Biofield practitioners have a holistic focus. About 50,000 practitioners provide 18 million sessions annually in the United States. (NIH, 1992.) Bioenergetics, also a method of massage/bodywork, is defined as a system of techniques for mobilizing the energies of people whose forms of expression have become in some way blocked or disturbed. Practitioners utilize movements and fundamental rhythmic processes of the body, particularly breathing. (Sale, 1994)

Chelation: Under federal law, the Health Care Financing Administration defines chelation therapy as the "application of techniques for the therapeutic or preventive effects of removing unwanted metal ions from the body." (Sale, 1994)

Chiropractic: Chiropractic science is concerned with investigating the relationship between structure (primarily of the spine) and function (primarily the nervous system) of the human body to restore and preserve health. Chiropractic medicine applies such knowledge to diagnosing and treating structural dysfunctions that can affect the nervous system. Chiropractic physicians use manual procedures and interventions, instead of surgery or chemotherapy. In 1993, more than 45,000 licensed chiropractors were practicing in the United States. Chiropractic specialty areas are extremely pertinent to other medical specialties, such as radiology, orthopedics, neurology, and sports medicine. Current chiropractic research interests include back and other pain, somatovisceral disorders and reliability studies. (NIH, 1992)

Curanderismo: A Latin American folk system of medicine that includes two distinct components: a humoral model for classifying activity, food, drugs, and illness; and a series of folk illnesses. In the humoral component of curanderismo, things could be classified as having qualitative (not literal) characteristics of hot or cold, dry or moist. According to this theory, good health is maintained by maintaining a balance of hot and cold. Thus, a good meal will contain both hot and cold foods, and a person with a hot disease must be given cold remedies and vice versa. Again, a person who is exposed to cold when excessively hot may "take cold" and become ill. (NIH, 1992)

Dance Therapy: Federal law specifies that "dance-movement therapy" is a process of psychotherapeutic movement facilitated by a dance-movement therapist to improve emotional, cognitive, or physical health. (Sale, 1994)

Environmental Medicine: Environmental medicine can be viewed as an extension of modern biomedicine. This therapy began with allergy treatment and the work of Dr. Theron Randolph in the 1940s. Dr. Randolph identified a variety of common foods and chemicals that were able to trigger the onset of acute and chronic illness even when exposure was at relatively low levels. Environmental medicine recognizes that illness in individuals can be caused by a broad range of inciting substances such as foods; chemicals found at home and in the workplace; chemicals in air, water, and food; and inhalant materials, including pollens, molds, dust, dust mites, and dander. Today there are 3,000 physicians worldwide practicing environmental medicine, and there are several environmental control units in the United States and one in Canada, where patients' sensitivities are unmasked through fasting and complete avoidance of potentially harmful chemicals. (NIH, 1992)

Feldenkrais: The Feldenkrais method endeavors to correct habitual negative patterns of movement on the premise that if these patterns are interrupted, the body will function with greater ease and fluidity and thereby improve a person's self-image, awareness, and health. Corrective techniques include the proper use of breath, movement sequences keyed to the client's unique needs to improve mobility, and communicative touch by the practitioner to enhance the client's sense of self-image and movement. (Sale, 1994)

Hellerwork: Hellerwork focuses on the synergistic relationship between the mechanical, psychological, and energetic functions of the body to facilitate structural realignment and an awareness of the mind/body relationship. Techniques utilized by Hellerwork practitioners include deep touch, movement and awareness education in relation to sitting, standing, walking, lifting, and running for purposes of reducing mechanical stress in the body and permitting more efficient use of personal energy. (Sale, 1994)

Herbal Medicine: Herbs may have been the first human healing system, and they are the mainstay of indigenous healing practices throughout the world. Many drugs commonly used today are of herbal origin. About one-quarter of the prescription drugs dispensed by community pharmacies in the United States contain at least one active ingredient derived from plant material. The World Health Organization estimates that 4 billion people, 80 percent of the world population, presently use herbal medicine for some aspect of primary health care. Herbal medicine is a major component in all indigenous peoples' traditional medicine and a common element in Ayurvedic, homeopathic, naturopathic, traditional oriental, and Native

American Indian medicine. Some of the most important and popular medicinal herbs are: Echinacea (Purple Coneflower), Ginger Rhizome, Ginkgo Biloba Extract, Ginseng Root, Wild Chrysanthemum Flower, Witch Hazel and Yellowdock. (NIH, 1992)

Homeopathy: Derived from the Greek word 'homolos,' meaning similar, and 'pathos,' meaning disease, is based on the law of similars, which states that a drug capable of causing symptoms similar to those of a disease can cure the disease. The principles of homeopathy were first described by Hahnemann in 1880. The first principle is the principle of "similars" which states that a drug will heal the symptoms similar to those it is known to cause. For example, according to homeopathic principles, a fever-producing drug can, in small doses, cure the fever. The second principle is that the diagnosis is made by studying "a pattern of symptoms" rather than just one or a few symptoms, and the patient is considered as a particular type exhibiting a specific body-mind pattern. The third principle believes in the safety of medication by using the smallest dose possible. A series of dilutions (potentizations) of the drug, are made to arrive at a dose that may be only a few hundred molecules. The fourth and final principle is the holistic idea that the healing process occurs at physical, emotional, and mental levels. (Kaul, 1996)

Hydrotherapy: This treatment employs water, ice, hot and cold temperatures through such procedures as full body immersion, baths, saunas, colonic irrigation, and compresses and packs. This treatment has been favorably noted for a variety of health problems involving stress, physical pain, toxic conditions, bacterial infections, and viruses. (Sale, 1994)

Hypnosis and Hypnotic Suggestion: The induction of trance states and the use of therapeutic suggestion were a central feature of the early Greek healing temples. Modern hypnosis began in the 18th century when Franz Anton Mesmer used "magnetic healing" to treat a variety of psychological and psychophysiological disorders, such as hysterical blindness, paralysis headaches, and joint pains. In the past 50 years, physicians, dentists, psychologists, and other mental health professionals have begun to use hypnosis more often. Today, it is widely used for addictions, such as smoking and drug use, for pain control, and for phobias such as fear of flying. (NIH, 1992)

Imagery: Imagery is both a mental process (as in imagining) and a wide variety of procedures used in therapy to encourage changes in attitudes, behavior, or physiological reactions. As a mental process, it is often defined as "any thought representing a sensory quality." The imagery includes the visual, aural, tactile, olfactory, proprioceptive, and kinesthetic senses. (NIH, 1992)

Massage Therapy: This is one of the oldest methods of health care practice. It is the scientific manipulation of the soft body tissues in order to return them to their normal state. Massage consists of a group of manual techniques that include applying fixed or movable pressure and holding and causing the body to move. Massage therapists primarily use their hands. In addition they may use their forearms, elbows, and feet. These techniques can affect the musculoskeletal, circulatory-lymphatic, and nervous systems. Massage therapy encompasses the concept of vis medicatrix naturae - helping the body heal itself - and is

aimed at achieving or increasing health and well-being. Touch is the fundamental medium of massage therapy. (NIH, 1992) Massage therapy techniques include Swedish massage, deep-tissue massage, sports massage, neuromuscular massage, and manual lymph drainage. Other physical healing methods include reflexology, zone therapy, tuina, acupressure, Rolfing, Trager, Feldenkrais method, and Alexander technique. (NIH, 1992)

Meditation: A self-directed practice for relaxing the body and calming the mind. Most meditative techniques have come to the West from Eastern religious practices, particularly India, China, and Japan. Until recently, the primary purpose of meditation has been religious, although its health benefits have been recognized. During the past 15 years, it has been explored as a way of reducing stress on both mind and body. Cardiologists, in particular, often recommend it as a way of reducing high blood pressure. (NIH, 1992)

Mind-Body Therapy: These types of therapies are based on an understanding of the profound interconnectedness of mind and body. This modality also finds social, economic and familial factors to affect and modify all aspects of individual health and illness. Specific Mind-Body interventions include: art therapy, biofeedback, counseling, dance therapy, guided imagery, humor therapy, hypnotherapy, meditation, music therapy, prayer therapies, psychotherapy, relaxation therapy, support groups, and yoga. (NIH, 1992)

Music Therapy: Under the federal Older Americans Act, music therapy is defined as the "use of musical or rhythmic interventions specifically selected by a music therapist to accomplish the restoration, maintenance, or improvement of social or emotional functioning, mental processing, or physical health of an older individual."(Sale, 1994)

Naprathrapy: This treatment has been defined as the evaluation of persons with connective tissue disorders through the use of naprapathic case history and palpation or treatment of persons by the use of connective tissue manipulation, therapeutic and rehabilitative exercise, postural counseling, nutritional counseling, and the use of the effective properties of physical measures of heat, cold, light, water, radiant energy, electricity, sound and air, and assistive devices for the purpose of preventing, correcting, or alleviating a physical disability. (Sale, 1994)

Native American Indian: These community-based medical systems all share the following rituals and practices: sweating and purging, usually done in a "sweat lodge"; the use of herbal remedies gathered from the surrounding environment and sometimes traded over long distances and shamanic healing involving naturalist personalistic healing. Tribes such as the Lakota and Dineh (Navajo) also use practices such as the medicine wheel, sacred hoop, and the "sing," which is a healing ceremonial that lasts from two to nine days and nights and is guided by a highly skilled specialist called a "singer."(NIH, 1992)

Naturopathic medicine: The practice of naturopathic medicine includes the following diagnostic and treatment modalities: utilization of all methods of clinical and laboratory diagnostic testing including diagnostic radiology and other imaging techniques; minor surgery

and naturopathic obstetrics (natural childbirth), nutritional medicine, psychotherapy and counseling; dietetics and therapeutic fasting; medicines of mineral, animal and botanical origin; hygiene and public health measures; homeopathy; acupuncture; chinese medicine; naturopathic physical medicine, including naturopathic manipulative therapies; hydrotherapies; heat and cold; ultrasound; and therapeutic exercise. (See also: Traditional Naturopathy)

Osteopathic medicine: This was one of the first health care systems to use manual healing methods in the United States. In 1993, more than 32,000 licensed osteopaths were practicing in the United States. More than 60 percent of osteopathic physicians are involved in primary care, including: family medicine, pediatrics, internal medicine, and obstetrics-gynecology. An extensive body of work supports the use of osteopathic techniques for musculoskeletal and nonmusculoskeletal problems.

Polarity Therapy: Considered to reflect an understanding of the nexus between energy blockages in the body and resulting illness. To release these blockages and restore the natural flow of energy, polarity practitioners use such measures as manipulation of pressure points and joints, massage, breath work, hydrotherapy, reflexology, and the holding of energy points on the body. This modality also employs stretching and other exercises, as well as dietary counseling and emotional balancing techniques. (Sale, 1994)

Prayer and Mental Healing: Both healing techniques fall into two main types. In Type I healing, the healer enters a prayerful, altered state of consciousness in which he views himself and the patient as a single entity. There need be no physical contact and there is no attempt to "do anything" or "give something" to the person in need, only the desire to unite and "become one" with him or her and with the Universe, God, or Cosmos. Type II healers, on the other hand, do touch the patient and describe some "flow of energy" through their hands to the patient's area of pathology. Feelings of heat are common in both healer and patient. (NIH, 1992)

Psychotherapy: Addresses a person's emotional and mental health, which is, closely interwoven with his or her physical health. This therapy encompasses a wide range of specific treatments from combining medication with discussion, to simply listening to the concerns of a patient, to using more active behavioral and emotive approaches. Conventional psychotherapy is conducted primarily by means of psychologic methods such as suggestion, persuasion, psychoanalysis, and reeducation. (NIH, 1992)

Reflexology: The North Dakota Reflexology Practice Act defines reflexology as application of specific pressure by the use of the practitioner's hands, thumbs, and fingers to reflex points in the client's hands, feet, or ears using alternating pressure, and such techniques as thumb walking, finger walking, hook and backup, and rotation on a reflex. (Sale, 1994)

Reiki: The modality of reiki functions on the premise of the existence of a universal life energy (ki), the activation of which through the touch of the practitioner's hands serves to balance and replenish personal energy, to remove energy blockages that lead to unhealthy conditions and to maintain a sense of well-being within a holistic paradigm of health. (Sale, 1994)

Rolfing: The practice of Rolfing is based on an understanding of the effect of bodily structure on a person's physiological and psychological state. Through the use of pressure applied with the fingers, knuckles, and elbows, the Rolfing practitioner endeavors to manipulate and stretch the body's fascial tissues to reestablish proper physical alignment of the head, torso, pelvis, legs, feet, and to promote associated mental and emotional balance. (Sale, 1994)

Shiatsu: Practitioners of shiatsu apply deep pressure along the acupuncture meridians of the body to stimulate the flow of life energy (chi) to remove energy blockages to healing. Pressure is applied principally by the fingers, but may also be administered through the knees, elbows, toes, heels of the hands and feet, and the pad of the practitioner's foot. Shiatsu is a method of massage/bodywork. (Sale, 1994)

Touch Therapy: Many alternative modalities involve the use of touch in one form or another to achieve therapeutic benefits. Less generically, the specific modality of "Therapeutic Touch" has been described as "a contemporary interpretation of several ancient healing practices in which the practitioners consciously direct or sensitively modulate human energies." Practitioners of the modality known as Therapeutic Touch generally do not actually touch the body of the patient, but endeavor to assess and remove blockages in the patient's energy field through slow and rhythmic movements of the practitioner's hands several inches from the patient's body. (Sale, 1994)

Traditional Naturopathy: This means a distinct system of non-invasive health care and health assessment in which neither surgery nor drugs are used, dependence being placed only on education, counseling, naturopathic modalities, and natural substances, including without limitation, the use of foods, food extracts, vitamins, minerals, enzymes, digestive aids, botanical substances, topical natural substances, homeopathic preparations, air, water, heat, cold, sound, light, the physical modalities of magnetic therapy, naturopathic non-manipulative bodywork, and exercise to help stimulate and maintain the individual's intrinsic self-healing processes. (See also: Naturopathic Medicine)

Traditional Oriental Medicine: A set of many systematic techniques and methods, including: acupuncture, herbal medicine, acupressure, qigong, and oriental massage. Oriental medicine emphasizes disturbances of "qi," or vital energy, as a critical element of health and disease. Diagnosis in oriental medicine involves observation, listening, questioning, and palpation, including feeling pulse quality and sensitivity of body parts. In the United States, the professional practitioner base for oriental medicine is organized around acupuncture and oriental massage. There are about 6,500 acupuncturist practitioners in the United States. The American Oriental Body Work Therapy Association has approximately 1,600 members representing practitioners of tuina, shiatsu, and related techniques. Many American schools of acupuncture are evolving into "colleges of oriental medicine" by adding courses in oriental massage, herbal medicine and dietary interventions. They also are offering diplomas, master's degrees, and doctor's degree in oriental medicine. The legal sanctioning of oriental medical practice is most extensive in New Mexico, where the acupuncture community has established an exclusive profession of oriental medicine. Their legal scope of practice is currently similar to that of primary care medical doctors (M.D.) and doctors of osteopathy (D.O.), and their state statute restricts other licensed New Mexico health professionals' ability to advertise or bill for oriental medicine or acupuncture services. The use of traditional oriental herbal

medicines and formulas in China and Japan has been studied for therapeutic value in the following areas: chronic hepatitis; rheumatoid arthritis; hypertension; atopic eczema; various immunologic disorders, including acquired immunodeficiency syndrome (AIDS); and certain cancers.

Trager: Trager therapy uses gentle, rhythmic touch and movement exercises to facilitate awareness and release of tension arising from habitual patterns of posture and movement. Trager aims to use motion in muscles and joints to produce particular sensory feelings, namely positive, pleasurable feelings that enter the central nervous system and begin to trigger tissue changes by means of the many sensory-motor feedback loops between the mind and the muscles. (D.Sale, Fetzer Institute)

Yoga is a way of life that includes ethical precepts, dietary prescriptions, and physical exercise. It is considered to have the capacity to alter mental and bodily responses normally thought to be far beyond a person's ability to modulate them. (NIH Report)

Appendix D

APPENDIX D

Regulation of CAM in Other States

(Source: Sale, 1994)

A. Provider Practice Acts

1. Acupuncture

The healing art of acupuncture is presently regulated by practice acts in over thirty states and in the District of Columbia.

a. Scope of Practice. Although statutory definitions of what constitutes the practice of acupuncture vary, the modality is frequently described as the stimulation of certain points on or near the surface of the human body by the insertion of needles to prevent or modify the perception of pain, to normalize physiological functions, or to treat certain diseases or dysfunctions of the body. The distinctively energetic quality of acupuncture is noted in several statutes which reference its utility in "controlling and regulating the flow and balance of energy in the body," or in "normalizing energetic physiological function." Many statutes define acupuncture on the basis of "traditional" Chinese or Oriental medical concepts, while laws in other jurisdictions also reference modern Chinese or Oriental medical concepts or modern techniques of diagnostic evaluation.

State enactments authorize acupuncturists to employ a wide variety of adjunctive therapies in the course of administering acupuncture treatment. The number and type of specific therapies differs from state to state, but the following composite list drawn from applicable practice acts illustrates the broad range of supplementary techniques authorized under current law:

- Moxibustion;
- Cupping;
- Mechanical, thermal, electrical, and electromagnetic treatment;
- Dietary guidelines;
- Therapeutic exercise;
- Oriental or therapeutic massage;
- Acupressure;
- Breathing techniques;
- Herbs, vitamins, minerals, and drugless substances;
- Oriental medical therapies;
- Dermal friction technique;
- Infrared;
- Sonopuncture;
- Laserpuncture;
- Point injection therapy (aquatherapy); and
- Lifestyle counseling.

b. Administrative Structure. In jurisdictions that have provider practice acts for acupuncture, the regulatory authority structure varies substantially. Six states have established acupuncture boards composed principally of non-physician acupuncturists and charged with exercising independent regulatory authority over the profession. In thirteen jurisdictions, a medical board exercises administrative control over acupuncture, often with the assistance of an acupuncture board or committee. Eight states regulate the profession above the board level within a state agency, usually with the assistance of an acupuncture unit whose authority varies from state to state.

Provider practice acts in several states utilize mixed forms of authorization in requiring both licensure and registration or in mandating a choice between registration or certification. Atypically, a very brief enactment in South Carolina requires "approval" from the state medical board to practice acupuncture and makes no reference to licensure, registration, or certification.

c. Medical Supervision. Acupuncture laws in some states require non-physician practitioners to be supervised by a licensed physician or occasionally by some other provider. The nature and extent of this requirement varies depending on the particular statute. The law may necessitate a referral from a physician before the commencement of acupuncture treatment, prior evaluation of the patient by a physician, direct employment or supervision of an acupuncturist by a physician or physician acupuncturist, or notifying a patient of the importance of consulting a medical doctor concerning the patient's condition.

d. Practice Rights of Other Providers. The right to practice acupuncture may extend to a variety of providers from other health disciplines. Depending on the state, practice rights may extend to medical doctors, osteopaths, chiropractors, physician assistants, naturopaths, homeopaths, podiatrists, nurses, veterinarians, and dentists. Training requirements in acupuncture for other practitioners are similarly diverse. The new law in Iowa, for example, requires acupuncturists to register with the state medical board and to meet examination and training standards established by the board. Before receiving acupuncture treatment, an acupuncture client must have a medical evaluation by and a referral from a medical doctor, osteopath, chiropractor, podiatrist, or dentist. The law holds an acupuncturist to the same standard of care as a licensed medical doctor or osteopath.

In contrast to the Iowa statute, North Carolina law establishes an Acupuncture Licensing Board with independent regulatory authority over the profession. The act mandates licensure for all acupuncturists, except physicians, chiropractors, and students practicing under the direct supervision of a licensed acupuncturist. Among other powers, the board is authorized to exercise disciplinary authority over licensees, to establish requirements for and approve schools of acupuncture in the state, and to formulate practice parameters for acupuncture.

e. Federal Developments. In 1973 the federal Food and Drug Administration (FDA) deemed acupuncture needles to be "experimental devices" and subject to cautionary labeling requirements and restrictive classification under the Food, Drug, and Cosmetic Act. The FDA's determination reflected its view that "until evidence is obtained demonstrating that acupuncture is a safe and effective medical technique, acupuncture devices must be limited to

investigational or research use." Accordingly, the use of acupuncture needles, stimulator and other accessories had to occur under the direct supervision of a licensed medical or dental practitioner and with the informed consent of the patient, who was viewed as a research subject. If any acupuncture device were shipped in interstate commerce under a claim that the device had diagnostic or therapeutic effectiveness, the FDA would regard the device as misbranded under the law.

The FDA subsequently modified its position in 1987 to the extent of permitting health professionals who are not physicians or dentists, but who are otherwise legally qualified as health care providers, to conduct acupuncture investigations. Acupuncture devices, however, must still be labeled as investigational and may not be advertised, promoted, contain claims for therapeutic use or specific medical conditions.

In 1994 multiple citizen petitions were filed with the FDA on behalf of the acupuncture community to reclassify the status of acupuncture needles under the Food, Drug, and Cosmetic Act from experimental devices (Class III) to devices for which performance standards exist to provide reasonable assurance of their safety and effectiveness (Class II).

Reclassification of acupuncture devices by the FDA as safe and effective would enhance the prospect of coverage for acupuncture treatment under federal Medicare and Medicaid. The federal Health Care Financing Administration (HCFA), which is responsible with administering the Medicare Program, currently denies coverage for acupuncture pending establishment of the scientific efficacy of this modality. With a showing of such efficacy, HCFA may consider acupuncture as a "reasonable and necessary" service for which coverage is authorized under the federal Social Security Act.

2. Homeopathy

Homeopathy practice acts currently exist in three states: Arizona, Connecticut, and Nevada. In states that do not have homeopathy practice acts, practice rights for this modality may be recognized within the scope of practice for other health care professions.

a. Scope of Practice. In Arizona, homeopathy is legislatively defined as a "system of medicine employing substances of animal, vegetable or mineral origin which are given in microdosage and prepared according to homeopathic pharmacology, in accordance with the principle that a substance which produces symptoms in a healthy person can cure those symptoms in an ill person." The statute permits homeopaths to employ as adjunctive therapies acupuncture, neuromuscular integration, orthomolecular therapy, nutrition, chelation therapy, pharmaceutical medicine, and minor surgery.

In Nevada, the homeopathy practice act similarly defines homeopathy by reference to the administration in microdoses of animal, vegetable, or mineral origin. The act further recognizes the homeopathic principle that a substance which produces symptoms in a healthy person can eliminate those symptoms in an ill person, thereby resulting in the elimination and prevention of illness through utilization of classical methodology and noninvasive electrodiagnosis.

The Connecticut statute does not define homeopathy or specify adjunctive therapies. Applicable administrative guidelines provide, however, that the required licensing examination is based primarily upon the principles of classical homeopathy.

b. Administrative Structure. Both Arizona and Nevada have independent homeopathy boards. In Connecticut the state Homeopathic Medical Examining Board functions principally as an advisory unit to the state Department of Public Health and Addiction Services. However, the board has independent authority to hear and decide matters concerning suspension or revocation of licenses, to adjudicate complaints against practitioners, and to impose related sanctions.

All three states utilize licensure to authorize the practice of homeopathy. The laws in Arizona and Nevada specify the powers and duties of the independent homeopathy boards, qualifications for licensure, disciplinary grounds against licensees, prohibitions and penalties for violations of the law. By contrast, Connecticut homeopathy licensure is contained within the statutory provisions concerning the practice of medicine and the general regulatory authority of the Department of Public Health and Addiction Services.

c. Practice Rights of Other Providers. Although formal homeopathy practice acts exist in only three jurisdictions, the right to utilize homeopathy is granted in other states as part of the scope of practice for such alternative modalities as naturopathy, oriental medicine, and chiropractic.

d. Federal Developments. The federal Food, Drug, and Cosmetic Act deems articles listed in the Homeopathic Pharmacopoeia of the United States (HPUS) as "drugs" and recognizes HPUS as the official compendium of standards for source, composition, and preparation of homeopathic products. Policy guidelines published by the FDA in 1988 note the transition of the homeopathic drug market in the United States from a historically limited position to a multimillion dollar industry and indicate that homeopathic products offered for the treatment of serious diseases must be dispensed under the care of a licensed practitioner. For self-limiting conditions that are recognizable by consumers, homeopathic preparations may be marketed over-the-counter.

Homeopathic drugs must meet standards specified in HPUS for strength, quality, and purity and comply with labeling, packaging, and manufacturing requirements specified in the federal act and applicable regulations. In recognition of the unique, highly diluted nature of homeopathic drug preparations, the FDA exempts these products from rules concerning expiration dating, as well as requirements for laboratory testing to determine the identity and strength of each active ingredient before distribution of the product.

3. Massage

Twenty jurisdictions have provider practice acts recognizing massage as a credentialed profession. Massage is also often regulated by political subdivisions within a state, even in jurisdictions that have adopted practice acts at the state level.

a. Scope of Practice. Although the legislative definition of massage is not uniform among the states, most statutes refer to this modality as the manipulation or treatment of the

soft or superficial tissues or muscles of the body by manual or mechanical means. A few enactments specify that, in addition to using the hands, a massage provider may employ the feet, arms, and elbows. Over half of the practice acts authorize such core massage techniques as friction, stroking (effleurage), percussion (tapotement), kneading (petrissage), and vibration.

The laws are diverse in specifying methods adjunctive to massage, but the following composite list is illustrative of the range of procedures currently permitted under the various practice acts:

- Topical applications (e.g., oils, lotions, powders, antiseptics, rubbing alcohol, creams, and ointments);
- chemical or herbal applications to body;
- heat lamps, infrared heat;
- salts and salt glow;
- hot or cold packs, ice;
- tub, shower, steam, dry heat, cabinet baths, whirlpool, sauna baths, sitz baths;
- hydrotherapy;
- heliotherapy;
- electrotherapy;
- mechanical devices which mimic or enhance hand action;
- Swedish gymnastics, medical gymnastics;
- reflexology;
- shiatsu;
- range of motion;
- nonspecific stretching;
- passive joint movements within normal physiologic range of motion; and
- rehabilitative procedures involving the muscles through noninvasive means and without spinal manipulation.

b. Administrative Structure. Among those jurisdictions that recognize massage as a credentialed profession, eight states have established massage boards with independent or substantially independent regulatory authority. In eleven states the profession is regulated at the departmental level, usually with the assistance of a massage board or advisory unit. Exceptionally, Ohio treats massage as a limited branch of medicine under the jurisdiction of the state medical board.

The administrative structure for the regulation of massage in Delaware is unique. In what may become a model concept for the joint regulation of massage and other alternative modalities involving bodywork, in 1992 Delaware established a seven member Committee on Massage/Bodywork Practitioners composed of four professional members and three representatives from the general public. The eclectic focus of the statute is evident in the Committee's authority to recognize schools and teachers of any method of massage/bodywork, including Alexander technique, therapeutic technique, Feldenkrais, Hellerwork, Oriental bodywork, Rolfing, Trager, bioenergetics, and shiatsu.

Fifteen states authorize massage practice rights through licensure. Three jurisdictions require registration and one state issues certifications for the profession. Maine has a bifurcated system in which "massage practitioners" receive registrations and more formally qualified "massage therapists" receive certificates.

c. Practice Rights of Other Providers. Due to the breadth of existing statutory definitions of massage, the scope of practice for this modality may affect the right of other alternative providers to practice their own distinctive modalities. Depending on the state, current laws may explicitly subject practitioners of reflexology, shiatsu, acupressure, polarity, touch therapy, and unspecified forms of "body therapy" or "bodywork" to requirements applicable to massage.

In other jurisdictions, however, massage practice acts deliberately exclude certain alternative providers. Maine, for example, does not apply its massage law to practitioners of Rolfing, Trager, reflexology, shiatsu, reiki, and polarity, if these providers do not use the title "massage therapist" or "massage practitioner." New Mexico exempts sobadores and Native American healers from the requirements of the state massage practice act as long as these practitioners use traditional Hispanic or Native American healing practices.

In certain jurisdictions massage may be lawfully practiced by naturopaths, acupuncturists, chiropractors, podiatrists, and physical therapists.

d. Local Regulation. Unlike other alternative modalities, massage is often regulated directly at the local level within a state by counties or municipalities. Even in jurisdictions that have state massage practice acts, legislative deference to local regulation is generally present, although the degree and specific type of deference varies under each practice act.

4. Naturopathy

Naturopathy practice acts currently exist in nine jurisdictions. In states that do not have naturopathy practice acts, the use of naturopathy may be considered to be the practice of medicine for which a medical license is required. To practice naturopathy may also require licensure in another health profession with a scope of practice that permits the use of naturopathic methods.

a. Scope of Practice. A common characteristic of the legislative definitions of naturopathy is an emphasis on the use of "natural" forms of health care treatment. Accordingly, references may be found in the practice acts to treatments by "natural means," "natural methods," "naturally occurring substances," "natural medicine," "natural therapeutics or procedures," or "nature's remedies." Several enactments also define this modality in terms of an understanding regarding a natural human capacity for self-healing.

In some jurisdictions, the scope of practice for naturopathy includes alternative modalities such as acupuncture, biofeedback, homeopathy, hypnotherapy or massage. A few statutes permit naturopaths to perform minor surgery and naturopathic or natural childbirth. In general, the practice acts allow naturopaths to utilize an extensive array of adjunctive therapies and procedures. The following itemization of the New Hampshire law illustrates the range of possible forms of therapy:

- Physical agents (air, water, heat, cold, sound, light, and electromagnetic nonionizing radiation);
- Physical modalities (electrotherapy, diathermy, ultraviolet light, ultrasound, hydrotherapy, naturopathic manipulative therapy, and therapeutic exercise);
- Natural medicines and therapies for preventive and therapeutic purposes (food, food extracts, vitamins, minerals, enzymes digestive aids, whole gland thyroid, plant substances, all homeopathic preparations, topical medicines, counseling, hypnotherapy, biofeedback, dietary therapy, naturopathic physical medicine, therapeutic devices, and barrier devices for contraception);
- Diagnostic procedures (physical and orificial examinations, x-rays, electrocardiograms, ultrasound, phlebotomy, clinical laboratory tests and examinations, and physiological function tests);
- Nonprescription medications and therapeutic devices;
- Diagnostic procedures commonly used by medical practitioners in general practice;
- Naturopathic childbirth; and
- Acupuncture.

b. Administrative Structure. Of the nine jurisdictions with naturopathy practice acts, five states have established independent boards to regulate this profession. Three states regulate naturopathy at the departmental level, with assistance from a naturopathy board or advisory committee. In the District of Columbia, naturopaths must register with the office of the Mayor.

With the exception of the very brief registration law in the District of Columbia, all of the practice acts authorize naturopaths through licensure. In several states, naturopathy licensees must also have a special certificate to practice natural childbirth, acupuncture, or to dispense a natural substance or device.

Practice Rights of Other Providers. Unlike the alternative modalities of acupuncture, homeopathy, and massage, which may be explicitly authorized as adjunctive therapies in the practice act of another health care discipline, the right to practice "naturopathy" does not appear to be positively conferred in the practice acts of other providers. On the other hand, the multiplicity of therapies and techniques that typically comprise the legislative definition of naturopathy may often fall within the scope of practice for other professions. The Montana Naturopathic Practice Act expressly acknowledges this fact:

This naturopathy practice act recognizes that many of the therapies used by naturopathic physicians, such as the use of nutritional supplements, herbs, foods, homeopathic preparations, and such physical forces as heat, cold, water, touch, and light, are not the exclusive privilege of naturopathic physicians, and their use, practice, prescription, or administration by persons not licensed to practice naturopathic medicine is not prohibited by this practice act.

Accordingly, naturopathy practice acts in Montana and in several other jurisdictions broadly provide that these enactments are not applicable to persons authorized to practice other health professions under state law. In other states, however, naturopathy practice acts limit the

categories of providers who may indirectly benefit in this way by excluding specific practitioners, such as physicians, osteopaths, chiropractors, Christian Scientists, or providers of Oriental medicine, Oriental herbology, or of other dietary or nutritional advice.

Implicit authorizations for other providers to practice naturopathic therapies may also arise under a statute that prohibits the practice of naturopathy as a distinct profession within a given state. Tennessee law, for example, provides that the practice of naturopathy is a Class B misdemeanor, but renders this prohibition inapplicable to "persons who comply with the regulatory laws of the state with respect to the practice of the various healing arts." Without a similar textual qualification, however, a South Carolina statute prohibits the practice of naturopathy and subjects offenders to a criminal fine of not more than one year, or both fine and imprisonment in the discretion of the court.

5. Other Alternative Modalities

Apart from modalities that are fully regulated by provider practice acts, alternative health care legislation in the U.S. also consists of references to specific therapeutic techniques that have been incorporated in statutes defining scope of practice for more comprehensively regulated modalities. Among the therapies included in this category however, naprathery, oriental medicine, art therapy, and reflexology, are each subject to licensure in its own right in at least one state.

6. Acupressure

State statutes generally treat acupressure as an adjunct therapy to either acupuncture or massage. Acupressure is also referenced in Washington's chiropractic practice act, which prohibits the state chiropractic board from adopting educational standards that mandate the study of acupressure as a requirement of graduation from or accreditation of chiropractic schools and colleges, or that include this modality in computing the hours required for chiropractic instruction.

7. Alexander Technique

Alexander technique is deemed a method of "massage/bodywork" under the Delaware Massage/Bodywork Practitioner Act and may be taught by schools and teachers that the state Committee on Massage/Bodywork Practitioners recognizes for purposes of the voluntary certification program established by this law.

8. Aromatherapy

The activities and services of aromatherapists are excluded from the law requiring licensure for counseling professionals in Maine. There appear to be no other statutory references to this modality.

9. Art Therapy

In New Mexico art therapists are subject to licensure under the state Counseling and Therapy Practice Act.[130] Art therapy services include, but are not limited to, diagnostic evaluation, development of patient treatment plans, goals and objectives, case management services and therapeutic treatment. The New Mexico act further requires that a professional art therapist be a member of the state Counseling and Therapy Practice Board, specifies educational

experience, and examination requirements for art therapists, and subjects licensees to disciplinary standards in common with other counselors and therapists regulated by the act.

In other states art therapy is not subject to licensure in its own right. Thus, in California art therapists are specifically excluded from licensing requirements applicable to psychiatric technicians, while in Maine an individual who works as an "expressive" art therapist is exempt from licensing standards governing counseling professionals. In the District of Columbia, art therapists are not subject to licensure requirements applicable to other regulated health occupations, provided the therapists work within the standards and ethics of the art therapy profession and do not identify themselves as practicing as a regulated health occupation.

At the federal level, the Older Americans Act authorizes grants to states to provide art therapy as a supportive service to enable older individuals to attain and maintain well-being. The act defines art therapy as the "use of art and artistic processes specifically selected and administered by an art therapist, to accomplish the restoration, maintenance, or improvement of the mental, emotional, or social functioning of an older individual."

10. Bioenergetics

Under the Massage/Bodywork Practitioners Act in Delaware, bioenergetics is deemed a method of massage/bodywork. The act permits the modality to be taught by schools and teachers that the state Committee on Massage/Bodywork Practitioners recognizes for purposes of the voluntary certification program established by the statute.

11. Biofeedback

Most state laws that refer to biofeedback authorize the use of this modality in the practice of psychology. The texts of applicable psychology practice acts do not formally define this modality, but occasionally reference its general function. Thus, California and Maryland permit the use of biofeedback instruments that do not pierce or cut the skin "to measure physical and mental functioning." Under Illinois law, biofeedback may be used to prevent or eliminate psychopathology or to ameliorate psychological disorders of individuals or groups. In three states, biofeedback is included within the scope of practice for physical therapists. The Colorado law permits a physical therapist to use biofeedback as a monitoring instrument "to detect and amplify internal physiological processes for the purpose of neuromuscular rehabilitation."

At the federal level, the Health Care Financing Administration authorizes coverage of biofeedback under Medicare only when it is reasonable and necessary for specific muscular reeducation or for treating pathological muscular abnormalities of spasticity, incapacitating muscle spasm, or weakness, and where more conventional treatments (i.e., heat, cold, massage, exercise, support) have not been successful. Moreover, biofeedback is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions.

12. Chelation

Chelation therapy is within the scope of practice for homeopathy in Arizona. The statute specifies that, except for the treatment of heavy metal poisoning, chelation therapy is an experimental form of treatment. The medical and osteopathic practice acts in Arizona provide that the use of chelation therapy in the treatment of arteriosclerosis or as any other form of therapy, with the exception of treatment for heavy metal poisoning, is a ground for discipline unless (1) the patient receives adequate informed consent, (2) the treatment conforms to generally accepted experimental criteria (including protocols, detailed records, periodic analysis of results, and periodic review by a medical peer review committee), and (3) the treatment is approved by the FDA.

Statutory tort law in Oklahoma also references chelation therapy and provides that, while the standard of care required of persons engaged in the healing arts in the state is determined by "national standards," this rule does not prohibit the use of chelation therapy. In 1993, South Dakota amended its medical practice act to prohibit the Board of Medical and Osteopathic Examiners in that state from basing a finding of unprofessional or dishonorable conduct solely on the basis that a licensee practices chelation therapy.

Under federal law, the Health Care Financing Administration defines chelation therapy as the "application of techniques for the therapeutic or preventive effects of removing unwanted metal ions from the body."

13. Dance Therapy

Although dance therapy does not appear to be formally defined by state legislation, federal law specifies that "dance-movement therapy" is a process of psychotherapeutic movement facilitated by a dance-movement therapist to further emotional, cognitive, or physical health.

Dance therapists are specifically excluded from licensure requirements applicable to psychiatric technicians in California. In the District of Columbia, a person who practices dance therapy must register with the mayor and may use the theories and techniques of this profession in accordance with appropriate ethical standards "to aid in the restoration and rehabilitation of mental and physical functions." The mayor of the District of Columbia is authorized to establish standards of education and experience as a condition of registration and may adopt the standards of recognized national professional associations of dance therapists for this purpose.

The federal Older Americans Act also recognizes the value of dance therapy in authorizing grants to the states to provide "dance-movement therapy" as a supportive service to enable older individuals to attain and maintain well-being.

14. Drugless Therapy

The use of drugless forms of healing is common among alternative health care modalities. Only a few statutes, however, explicitly reference drugless healing or drugless therapy as such. Under a 1980 California law, the designation of drugless practitioner was abolished, but persons who were then authorized to practice drugless therapy may continue their practice and

renew their licenses. The statute provides that the state certificate in this field authorizes the practitioner to "treat diseases, injuries, deformities, or other physical or mental conditions without the use of drugs or what are known as medical preparations and without in any manner severing or penetrating any of the tissues of human beings except the severing of the umbilical cord."

Washington law prohibits a person from practicing or representing himself or herself as a "drugless therapist" without a valid license. Moreover, any person who held a license to practice this therapy on January 1, 1988, is deemed licensed under the state naturopathic practice act. In Pennsylvania, a 1986 law provides that drugless therapists who have been licensed by the state medical board may continue to provide this type of treatment in accordance with regulations of the board.

In two jurisdictions, a person who holds a valid authorization from the state as a drugless practitioner is exempt from the requirements of the state massage laws. Elsewhere, isolated statutory references exist which declare or acknowledge drugless therapy or methods to be within the scope of practice of chiropractic or naturopathy.

15. Feldenkrais

Feldenkrais is a method of massage/bodywork under Delaware's Massage/Bodywork Practitioners Act. The modality may be taught by schools and teachers recognized by the Delaware Committee on Massage/Bodywork Practitioners under the state's voluntary certification program for practitioners in this field.

16. Hellerwork

The Massage/Bodywork Practitioners Act of Delaware recognizes Hellerwork as a method of massage/bodywork for purposes of the voluntary certification program authorized by that statute.

17. Herbology

Statutory authorizations for the therapeutic use of herbs are within the scope of practice for a number of alternative modalities. In Nevada and New Mexico, herbs may be used by practitioners of oriental medicine. The Nevada law defines "herbs" as "plants or parts of plants valued for medicinal qualities" and indicates that the practice of herbal medicine involves "suggesting, recommending, prescribing or directing the use of herbs for the cure, relief or palliation of any ailment or disease of the mind or body, or for the care or relief of any wound, bodily injury or deformity." In New Mexico, licensure requirements otherwise applicable under the Acupuncture and Oriental Medicine Practice Act, are not enforced against a person who provides information about the general use of herbal medicines. This privilege applies if the person does not hold himself or herself out as a doctor of oriental medicine or as a practitioner of acupuncture or oriental medicine.

The use of herbs is authorized under acupuncture practice acts in California, North Carolina, Oregon, and Texas. In California, a person who holds out publicly as an "Oriental herbalist" or as a "certified herbalist" must be licensed as an acupuncturist. The Virginia Acupuncture Act, however, states that the practice of acupuncture does not include the use of herbal preparations.

The naturopathy practice acts in several states permit the administration of herbal remedies and Oregon law requires the study of herbology as a condition of naturopathic licensure. In Alaska, herbs are considered a "dietetic" that may be employed by naturopaths. In Washington, "oriental herbology" is exempted from licensing requirements under the naturopathy practice act. Although Montana deems the use of botanical medicines to be within the scope of its naturopathy law, the statute recognizes that the use of herbs is not the exclusive privilege of naturopathic physicians and allows a person who is not licensed in naturopathy to use, prescribe, and administer these substances.

Florida recognizes the application of herbal preparations as within the scope of practice for massage, but exempts persons from the massage licensure requirement if they use herbal wraps to cleanse and beautify the skin or in conjunction with a weight loss program.

Chiropractors in New Mexico may employ herbal remedies, but in Washington the law would permit chiropractors to recommend nutritional supplements only and not medicines of herbal origin.

In Idaho, an unlicensed health care provider may administer herbal treatment or provide advice about the use of herbs if the provider obtains from each patient or client an informed consent authorization which provides an overview of the provider's education and states that the provider is not a medical doctor or osteopath nor licensed under the state medical practice act. In North Carolina, an herbalist who provides nutritional information and counseling concerning herbs is exempt from licensure requirements under the state Dietetics and Nutrition Law, provided the herbalist furnishes nonfraudulent nutritional information and counseling about the reported or historical use of herbs and does not hold out as a dietitian or nutritionist.

Federal regulation of herbs as dietary supplements under the Nutrition Labeling and Education Act of 1990 and the Dietary Supplement Health and Education Act of 1994, is noted in Part III-8 of this study.

18. Holistic Healing

The acupuncture practice act in California illustrates an awareness of the holistic healing paradigm as seen in the following statement: 'In its concern with the need to eliminate the fundamental causes of illness, not simply to remove symptoms, and with the need to treat the whole person, the Legislature intends to establish in this [act], a framework for the practice of the art and science of oriental medicine through acupuncture.' The purpose of this act is to encourage the more effective utilization of the skills of acupuncturists by California citizens desiring a holistic approach to health and to remove the existing legal constraints which are an unnecessary hindrance to the more effective provision of health care services. Also, as it affects the public health, safety, and welfare, there is a necessity that individuals practicing acupuncture be subject to regulation and control as a primary health care profession.

19. Hydrotherapy

Explicit statutory references to hydrotherapy appear most frequently in legislation recognizing this procedure as part of massage practice, course work, or as within the scope of practice for naturopathy. The use of hydrotherapy is also expressly permitted in some states for

chiropractors, physical therapists, and occupational therapists. In New Mexico, the right to use hydrotherapy extends not only to massage providers, but to other licensed practitioners of the healing arts, generally, including unlicensed persons who do not claim to be physical therapists and work under the immediate supervision of a healing arts licensee. In Delaware and South Dakota, athletic trainers may use hydrotherapy.

20. Hypnotherapy

Statutory references to hypnotherapy or hypnosis in the context of health occupations legislation generally do not provide a formal definition for this modality. However, Florida's "Hypnosis Law," recognizes that hypnosis "has attained a significant place as another technique in the treatment of human injury, disease, and illness, both mental and physical," and defines hypnosis as:

...hypnotism, mesmerism, posthypnotic suggestion, or any similar act or process which produces or is intended to produce in any person any form of induced sleep or trance in which the susceptibility of the person's mind to suggestion or direction is increased or is intended to be increased, where such a condition is used or intended to be used in the treatment of any human ill, disease, injury, or for any other therapeutic purpose.

Where referenced by statute in a health occupations context, hypnotherapy or hypnosis is predominately declared to be within the scope of practice of psychology. Depending on the state, practice rights may also extend to marriage and family counselors, anesthetists, naturopaths, clinical social workers, mental health counselors, medical practitioners, and healing arts licensees generally.

In Washington, hypnotherapists may register separately under a state credentialing act for counselors. The act expressly recognizes, however, the practice of hypnotherapy is not necessarily limited to counseling. A few states refer to both hypnosis and hypnotherapy in the same statute, but for different purposes. Thus, Missouri specifies that hypnosis is within the scope of practice for psychology, but excludes hypnotherapists from the associated licensure requirement.

The practice of hypnosis may be subject to varying statutory conditions relating to the educational qualifications and clinical experience of practitioners or to prohibitions on the use of hypnosis by dentists, optometrists, podiatrists, chiropractors, osteopaths, and physicians for neurotic difficulties of a patient, as opposed to its use for hypnoanesthesia or for allaying anxiety during health care treatment by these providers. In common with other counselors regulated by Washington's credentialing act for the counseling profession, a hypnotherapist must provide information to a client about the practitioner's practice, education and training, the patient's treatment options, and other matters specified in administrative rules of the state department of health.

21. Music Therapy

In California, music therapists are excluded from licensure requirements applicable to psychiatric technicians and in Texas, music therapy is deemed a related service (i.e., a noninstructional developmental, corrective, supportive, or evaluative service) for use with

disabled students. Under federal law, the Older Americans Act authorizes grants to states to provide music therapy as a supportive service to enable older persons to attain and maintain well-being.

22. Naprapathy

The Illinois naprapathy practice act defines naprapathy as :

“...the evaluation of persons with connective tissue disorders through the use of naprapathic case history and palpation or treatment of persons by the use of connective tissue manipulation, therapeutic and rehabilitative exercise, postural counseling, nutritional counseling, and the use of the effective properties of physical measures of heat, cold, light, water, radiant energy, electricity, sound and air, and assistive devices for the purpose of preventing, correcting, or alleviating a physical disability.”

The Illinois statute recognizes the application of naprapathy for a variety of health conditions, including the treatment of contractures, muscle spasms, inflammation, scar tissue formation, adhesions, lesions, laxity, hypotonicity, rigidity, structural imbalance, bruising, contusions, muscular atrophy, and partial separation of connective tissue fibers. The law requires naprapaths to be licensed, specifies associated educational and examination requirements, and imposes penalties for infraction by naprapathy licensees of various standards of professional conduct. The state Department of Professional Regulation administers the practice act with the advisory assistance of a seven member Naprapathic Examining Committee which reviews proposed regulations of the department concerning practitioners in this field. A naprapath must refer to a licensed physician, dentist, or podiatrist any patient whose medical condition, at the time of treatment, should be determined to be beyond the scope of practice for the naprapath. Certification for naprapathy as a limited branch of medicine by the state medical board in Ohio was discontinued after March 2, 1992, but naprapaths certified before that date may continue to practice under rules promulgated by the board.

23. Oriental Medicine

References to oriental medicine often appear in acupuncture practice acts in connection with the legislative definition of "acupuncture," with requirements concerning the use of professional titles for acupuncture, and as part of educational qualifications for acupuncture practitioners. In Nevada and New Mexico, however, oriental medicine is subject to licensure in its own right. Under Nevada law, oriental medicine is defined as a:

“...system of the healing art which places the chief emphasis on the flow and balance of energy in the body mechanism as being the most important single factor in maintaining the well-being of the organism in health and disease. The term includes the practice of acupuncture and other services approved by the Board of Oriental Medicine.”

The Nevada statute requires the board to issue separate licenses to practice oriental medicine and acupuncture and designates the licensees respectively as "doctors of oriental medicine" and "doctors of acupuncture." In common with provider practice acts for other health

professions, the act also specifies educational and training qualifications for licensure, provides for an examination, enforces disciplinary grounds for unprofessional conduct, and prohibits unauthorized practice.

The New Mexico licensure act for oriental medicine defines this modality as:

“...the distinct system of primary health care that uses all allied techniques of oriental medicine, both traditional and modern, to diagnose, treat and prescribe [techniques of oriental medicine] for the prevention, cure or correction of any disease, illness, injury, pain or other- physical or mental condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health...”

The techniques of oriental medicine to which the preceding definition applies include diagnostic and treatment procedures, acupuncture, moxibustion, manual therapy (tui na), breathing and exercise techniques, herbal and homeopathic medicine, vitamin, mineral, enzyme, glandular, or nutritional supplements, and dietary, nutritional, and life-style counseling.

Unlike the law in Nevada, the New Mexico practice act authorizes the state Board of Acupuncture and Oriental Medicine to issue only one license and designates the licensee as a "doctor of oriental medicine."

24. Polarity Therapy

In Maine, practitioners of polarity therapy are not subject to the requirements of the state massage practice act if the practitioners do not use the title "massage therapist" or "massage practitioner." In North Dakota, however, polarity is declared to be part of the practice of massage for which registration is required under the statute.

25. Reflexology

In 1993, North Dakota enacted the first reflexology practice act in the United States and established an independent administrative board to regulate this modality. The act defines reflexology as "application of specific pressure by the use of the practitioner's hands, thumbs, and fingers to reflex points in the client's hands, feet, or ears using alternating pressure, and such techniques as thumb walking, finger walking, hook and backup, and rotation on a reflex. The law prohibits a reflexology licensee from using lotions, creams, or mechanical devices in the application of reflexology or from diagnosing or treating specific diseases, practicing spinal or other joint manipulations, prescribing or adjusting medication, or prescribing or administering vitamins.

In other states, statutory references to reflexology are limited to including or excluding this modality from the scope of practice of massage. Thus, in Arkansas, reflexology is deemed a massage procedure, while in Washington a practitioner who uses the term "reflexologist" as a professional title or in describing the practitioner's services is treated as a massage practitioner and made subject to the licensure requirements of the state massage practice act. Maine, however, views reflexology as another form of tissue work beyond the purview of the massage practice act as long as the reflexologist does not use the title "massage therapist" or "massage practitioner."

26. Reiki

Reiki is specifically exempted from the requirements of the massage practice act in Maine. The statute declares reiki to be another "form of tissue work exclusive of massage therapy" as long as the reiki practitioner does not use the title "massage therapist" or "massage practitioner."

27. Rolfing

The few statutory references to Rolfing occur in the context of the regulation of massage. Under the Delaware Massage/Bodywork Practitioners Act, Rolfing is one of several modalities eligible for voluntary certification by the state. Maine law exempts Rolfing from the requirements of the massage practice act if Rolfing practitioners refrain from using the title "massage therapist" or "massage practitioner." Prior to 1993, Arkansas treated Rolfing as a form of massage therapy under the state massage practice act, but an amendment to the law in that year deleted the explicit statutory reference to this modality in favor of broad language that includes as part of massage "any hands-on bodywork techniques and procedures" that are not regulated by other licensing boards in the state. This expansive language presumably would continue to cover Rolfing as a "hands-on bodywork technique or procedure."

28. Shiatsu

Shiatsu is a method of massage/bodywork eligible for voluntary certification under the Delaware Massage/Bodywork Practitioners Act and an "equivalent team" for massage therapy under the massage practice act of Louisiana. Maine excludes shiatsu from the requirements of the state massage practice act, provided the shiatsu practitioner does not use the title "massage therapist" or "massage practitioner."

29. Spiritual Healing

State codes contain numerous provisions accommodating spiritual or religious healing practices. The specific nature of the accommodation varies, but often exists as an exemption from licensure or other state requirements, or as an affirmative benefit, such as coverage of spiritual healing under a health plan. New Mexico specifically exempts "metaphysical" practitioners from licensure requirements under the state psychology and counseling and therapy practice acts if the practitioner engages in nonclinical activities consistent with the standards and codes of ethics of that practice.

The succeeding discussion treats exemptions enjoyed by spiritual healers from licensure primarily under state medical practice laws. Exemptions of this type are particularly significant in light of the First Amendment's guarantee of the free exercise of religion and what would otherwise be an all-encompassing definition of the practice of medicine under the laws of most states.

The most common type of exemption permitted by state medical practice acts for spiritual healing is available only to persons whose healing method is in accordance with the practices or tenets of a "church." In a number of other states, the exemption is further narrowed to apply only to spiritual healers of a particular religious denomination, notably Christian Scientists. Several states explicitly or implicitly recognize the right of both Christian Scientists and persons from other unspecified religious denominations to engage in spiritual healing.

The particular "form" of the spiritual healing technique is significant in some jurisdictions for purposes of the exemption from medical licensure. Michigan, for example, authorizes the exemption only if the practitioner uses "prayer." In Vermont the exemption is not permitted for persons who attempt to cure disease by "faith cure," "mind healing," or the "laying on of hands," but is available to persons "who merely practice the religious tenets of their church without pretending a knowledge of medicine or surgery."

Oregon law is somewhat ambiguous concerning the form spiritual healing must take to qualify for an exemption from medical licensure as the applicable statute contains both permissive and restrictive standards. On one hand, the law specifies that the exemption is available not only to spiritual healers who use "prayer," but also to persons who employ "other spiritual means." On the other hand, this permissive authorization seems qualified in that the use of either form of healing must occur in accordance with the tenets of a "church." Within this legal framework, however, the same statute contains the following broad disclaimer regarding the selection and use of a particular form or provider of spiritual healing:

Nothing in this medical practice act interferes in any manner with the individual's right to select the practitioner or mode of treatment of an individual's choice, or interferes with the person so employed to give the treatment so chosen if public health laws and rules are complied with.

Constitutional and interpretative issues that might arise under some of the preceding laws are less apparent in other states where statutory exemptions from medical licensure seemingly apply whether or not the particular spiritual healing modality constitutes the tenets of a "church," is associated with a particular religious denomination, or assumes any prescribed form. Thus, a number of states, without any further qualifications regarding church tenets, denominational affiliation, or healing technique, have adopted straightforward statutes which broadly authorize the application of the medical licensure exemption for a person who uses prayer or mental or spiritual means. Enactment of similarly permissive exemptions may become increasingly important in other jurisdictions for spiritual healers whose contemporary practices do not fit the restrictive criteria found in many medical practice acts.

In addition to restrictions on spiritual healing that are keyed to denominational or church affiliation or to the form of the healing technique itself, the law in many states, including states whose statutes are otherwise permissive, nevertheless mandates compliance with other conditions to obtain an exemption from medical licensure. In general, these conditions are intended to ensure that spiritual healers avoid the use of medical titles, comply with public health and sanitation requirements, do not perform surgery, prescribe drugs or other medications.

30. Touch Therapy

There are few statutory references to touch therapy as a distinct modality. In the state of Washington, however, a person who designates himself or herself as a "touch therapist" is deemed to be a massage practitioner and subject to regulation under the state massage practice

act. "Touch" is noted as a massage procedure by the North Dakota massage practice law [274] and as a form of therapy used nonexclusively by naturopaths in Montana.

31. Trager

The Massage/Bodywork Practitioners Act in Delaware recognizes Trager for purposes of the voluntary certification program authorized by the act. Maine excludes this modality from the requirements of the state massage practice law if practitioners of Trager do not use the title "massage therapist" or "massage practitioner."

Medical Practice Acts

A. Alaska

In 1990, Alaska began what is now an emerging legislative trend among the states to address the interests of alternative physicians and their patients. The medical practice act in that state directs that the state medical board may not base a finding of professional incompetence solely on the basis that a licensee's practice is unconventional or experimental in the absence of demonstrable physical harm to a patient. Under this law, a showing of actual physical harm to a patient would seem necessary to support a finding of professional incompetence, regardless of the effectiveness of the therapy or the degree of intrinsic risk the therapy might pose for a patient before actual treatment.

B. Washington

The state of Washington amended its uniform disciplinary act in 1991 to declare that "the use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed. The reference in the Washington statute to the "unreasonable risk that a patient may be harmed" seems to provide the medical board in that state with greater administrative leeway in disciplining an alternative physician than is apparent under the law in Alaska. Specifically, the relevance of risk assessment under the Washington statute suggests that, even in the absence of actual physical harm to a patient, the medical board could take disciplinary action against an alternative physician for professional misconduct.

C. North Carolina

In 1993, North Carolina enacted a statute that keys the disciplinary authority of the state medical board explicitly to either (1) a comparison involving the relative safety of utilizing an alternative versus an allopathic form of treatment, or (2) an evaluation of the relative effectiveness of the alternative form of treatment itself. The law provides that:

"The Board shall not revoke the license of or deny a license to a person solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective."

Unlike the laws in Alaska and Washington, the North Carolina statute makes no direct reference to actual or potential harm to the patient, but imports a somewhat more abstract standard involving either (1) the effectiveness of the alternative treatment as such, or (2) a comparative standard assessment of its risk relative to a prevailing treatment.

In an actual case, it is arguable that the comparative safety or effectiveness evaluations mandated by the North Carolina law authorize the admission of a broader range of scientific and clinical evidence than would otherwise be possible under a statutory test that focuses solely on actual or potential harm to a specific patient.

D. South Dakota

In 1993, South Dakota enacted a more limited version of the preceding enactments in prohibiting the Board of Medical and Osteopathic Examiners in that state from basing a finding of unprofessional or dishonorable conduct solely on the basis that a licensee practices "chelation therapy." Of the six state laws that conditionally allow physicians to use alternative modalities, only South Dakota's statute predicates the practice rights of the physician on the use of a particular therapy.

E. New York

After several years of legislative consideration of a measure that would have required the informed consent of the patient and defined "alternative medical treatment" by reference to multiple institutional and scientific criteria, New York adopted a straightforward law in 1994 specifying that the medical practice act in that state may not be construed to affect or prevent "[the physician's use of whatever medical care, conventional or non-conventional, which effectively treats human disease, pain, injury, deformity or physical condition."

On its face, the New York statute seems more restrictive than Alaska's law, inasmuch as the failure of a treatment to cause "demonstrable physical harm to a patient," which is the litmus test under the Alaska statute, presumably would not demonstrate the effectiveness of the treatment for purposes of the New York enactment. On the other hand, to the extent that the validity of a particular therapy under New York's law would not be determined by the degree of risk to a patient before actual treatment, but solely on the basis of the treatment's effectiveness after administration to a patient, the New York legislation may be more permissive than the Washington statute. It is not clear, however, at least from the text of the New York law, when the effectiveness of a treatment must be determined.

New York law also alters the composition of the State Board for Professional Medical Conduct by requiring that, of the eighteen physician members of the board, no fewer than two must be physicians who dedicate a significant portion of their practice to the use of non-conventional medical treatments. New York state medical associations dedicated to the advancement of these treatments may nominate the two non-conventional physicians and make experts available for consultation in connection with the medical board's investigation of cases involving clinical practice. The law further mandates that the Physician Disciplinary Process Evaluation Panel, which is charged with assessing the quality of physician discipline in the

state, report to the Governor and legislature by June 1, 1995, concerning (1) the use of non-conventional medical experts in the investigation of complaints involving clinical practice, and (2) the appointment of non-conventional physicians to committees on professional medical conduct which hear a case involving a non-conventional physician.

F. Oklahoma

Oklahoma also enacted legislation in 1994 to accommodate alternative physicians by redesignating its medical practice act as the "Allopathic Medical and Surgical Licensure and Supervision Act" (emphasis supplied) and by adopting several related amendments to circumscribe the authority of the state medical board. Accordingly, nothing in the renamed act "shall prohibit services rendered by any person practicing any nonallopathic healing practice." Moreover, the state medical board may not deny a license to a person who is otherwise qualified to practice allopathic medicine under the act solely because that person practices a therapy that is experimental or nontraditional. Finally, the law prohibits the medical board from revoking the license of an otherwise qualified physician solely because the physician practices an experimental or nontraditional therapy.

Unlike other medical practice statutes that accommodate the practice rights of alternative physicians, the Oklahoma law does not specify the conditions under which the state medical board may take disciplinary action against a licensee. For example, there is no standard in the statute which keys the board's disciplinary authority to the risk or absence of harm to the patient or to the effectiveness of the alternative treatment. The law simply prohibits the board from revoking a license or taking disciplinary action "solely because the person's practice or a therapy is experimental or nontraditional." Compared to other statutes in this subject area, Oklahoma's law appears to grant the state medical board greater administrative flexibility in disciplining an alternative physician, particularly as the new legislation also preserves the pre-existing authority of the board to take disciplinary action "as deemed appropriate based upon the merits of each case."

Although, as indicated, the Oklahoma statute declares that the legislation does not prohibit services rendered by "any person practicing any nonallopathic healing practice," it is unclear whether this broad disclaimer automatically guarantees the practice rights of nonphysician alternative providers who are not otherwise authorized to practice under state law. In this regard, alternative practitioners may remain subject to another Oklahoma statute which generally requires all health care providers to be licensed or certified by the state to practice a healing art.

G. Maryland Commission on Complementary Medical Methods

After several years of unsuccessful legislative efforts to pass a statute along the lines of the ones in Alaska and Washington, Maryland in 1993 established a Commission on Complementary Medical Methods to study how to allow Maryland physicians to use alternative modalities with patients who wish to be treated in this way. The Commission is specifically charged with:

- identifying which health care methods are complementary medical methods being used by Maryland physicians;
- evaluating the costs, benefits, and risks associated with the use of complementary medical methods;
- determining how best to inform patients of the benefits and risks associated with the use of complementary medical methods and the availability of other methods of treatment; and
- reporting recommendations to the Governor and the General Assembly by December 1, 1995.

The Commission is composed of two members of the state legislature, the Secretary of the state Department of Health and Mental Hygiene, two members of the State Board of Physician Quality Assurance, two representatives from the Medical and Chirurgical Faculty of Maryland, one Maryland physician with expertise in the use of complementary medical methods, one person representing hospitals in the State, two patients or former patients of physicians who use complementary medical methods, and two members of the general public.

The principal accomplishment of the Commission to date has been the formulation of a definition of "complementary medical method" pursuant to its statutory charge. The definition follows the one used by the British Medical Association and states that complementary medical methods are "those forms of treatment which are not widely used by conventional health care professionals and the skills of which are not taught as part of the of conventional medical and paramedical health care." The Commission will terminate its existence after making its required report by December 1, 1995.

Appendix E

APPENDIX E

Examples of Insurance Coverage of CAM

(Source: Moore, 1997)

1. Washington state. A 1995 law mandated all carriers to cover alternative medicine, this law went into effect January 1, 1996 and requires health insurance plans in the state to provide access to every category of health care provider to treat conditions that would be covered under the state's Basic Health Plan. For example, if a benefit plan covered back pain, consumers would not be limited to conventional medicine in seeking treatment.

2. Blue Cross of Washington and Alaska conducted a pilot supplemental insurance plan called AlternaPath Nontraditional Health Care Program, from May 1994 to September 1995 for 1000 members in Washington. Now Blue Cross of Washington and Alaska covers alternative therapies as defined by state law, at 50 percent of the costs up to \$500 per year.

3. Mutual of Omaha companies have made Dr. Dean Ornish's program for reversing heart disease, which involves exercise, diet and yoga, a reimbursable benefit for any patient with coronary artery disease covered under its major medical policy. The plan reimburses policy holders with coronary artery disease who participate in Dr. Ornish's program in any one of eight facilities across the country.

4. Wellness Health Plans. The Wellness Plan has been available from American Western Life Insurance Company since January 1993 and encourages consumers to manage their own preventive care. Plan coverage varies by policy, but generally benefits include up to \$300 per year reimbursement for acupuncture, physical therapy and spinal treatments; other services may either be reimbursed or provided at a discount. The wellness plans are available in California, Colorado, Idaho, Indiana, Louisiana, Michigan, Missouri, Montana, Nevada, New Mexico, Oklahoma, Oregon, Tennessee, Texas, Utah and Wyoming.

5. Alternative Health Benefit Services negotiates and develops alternative health plans. The Alternative Health Plan features comprehensive major medical coverage, as well as partial reimbursement for alternative and complementary modalities. Physical medicine including appropriate acupuncture and chiropractic treatments has a maximum annual benefit of \$1000 with certain exceptions. Massage and bodywork by licensed, certified, or recognized technicians has a maximum benefit payment of \$25 per visit for 12 to 25 visits per benefit per year. Homeopathic and herbal remedies and Oriental medicine including dried medicinals and herbals are payable to a maximum benefit of \$500 per year when prescribed by a licensed physician for appropriate medical conditions. Chelation therapy is limited to a maximum payment of \$50 per visit, with a maximum number of 20 visits per benefit year. Mental health and substance abuse has a lifetime maximum benefit of \$10,000 and is limited to a maximum benefit of \$1000 per calendar year for combined inpatient/outpatient services. A subsidiary of Alternative Health Benefit Services is the **Alliance for Alternatives in Health care**, a national voluntary health care purchasing coalition designed to provide cost-effective medical coverage for its members featuring alternative medical benefits.

6. Kaiser Permanente and FHP are the two largest health plans in Colorado and have expanded their coverage to include chiropractic care. Kaiser Permanente and FHP will offer the coverage as an optional service available at an additional charge to employers with a small increase in monthly premiums for employees to have access to the service, as well as copayments.

7. Oxford Health Plans, which were the first large medical insurer to offer alternative medicine in its benefits, have a network including between 500 and 1000 chiropractors, acupuncturists, naturopaths, massage therapists, yoga instructors, registered dietitians and clinical nutritionists. (Kennedy, 1997) Oxford's alternative medicine program includes four components: a large credentialed network of alternative medicine providers; a benefit plan that includes coverage for alternative medicine services that can be purchased as a supplement to regular Oxford coverage; a mail-order service for purchasing vitamins, remedies, and alternative medicine products; and an information service to help members understand the alternative strategies used for various diseases and conditions. Oxford has also established three advisory boards to establish the quality standards required for chiropractors, acupuncturists and naturopaths to be admitted to the network. Criteria for admission include a license in the state in which they practice, graduation from a fully accredited college, demonstration of years of continuous clinical experience, pursuit of continuing education credits, and proper malpractice insurance. Members of Oxford Plans have access to special rates on vitamins and herbal supplements, health education books and tapes by mail order and educational seminars by providers and specialists.

8. Health Partners Health Plans Inc. (a result of the merger of Southern Arizona Tucson Medical Center and Phoenix based Samaritan Health Plan) has contracted with the Arizona Center for Health and Medicine which provides only alternative and complementary medicine. The physicians with whom Health Partners contracts are board certified in either family medicine or internal medicine and also in alternative therapies. This article notes that the process of including alternative therapists in health care benefits has fostered a new industry- that of credentialing practitioners.

9. American Medical Security Inc., a Wisconsin-based insurance company, is offering policies that cover biofeedback, acupuncture and hypnotherapy.

10. Kaiser Permanente has been using alternative medicine since 1994 in several clinics in northern California, primarily for pain management. (Berlin, 1997)

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