THE VIRGINIA BOARD OF HEALTH PROFESSIONS' REVIEW OF ALTERNATIVE AND COMPLEMENTARY MEDICINES

The Virginia Board of Health Professions commissioned this manuscript as part of its efforts to determine the appropriateness of laws regarding alternative and complementary treatments in the Commonwealth of Virginia. Initiative for this proposal came from the Chairperson of the Regulatory Research Committee who proposed the work after reading "NIH looks at the implausible and inexplicable" (Trachtman, 1994). That article will be referred to herein as the target article.

The Board of Health Professions is authorized to evaluate the need to regulate health professions and occupations and use appropriate methods for regulation, as well as to examine scope of practice conflicts involving regulated and unregulated professions, and "to advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts" (Code of Virginia, §§54.1-2510(2) and (12)).

The Board did not commission this work to determine the feasibility, or efficacy, of alternative or unconventional therapies. Instead, the purpose was to determine hindrances in accessing alternative medicine practitioners in the Commonwealth of Virginia. In addition, the Board requested developments in the legislation and research of alternative treatments. Recommendations concerning policy changes were beyond the scope of this study.

The presented work will first summarize the target article that compelled the Board of Health Professions to consider this issue. Following the summary, general information and research concerning alternative medicines, as well as insights as to why alternative medicines are used will be discussed. Since other states have addressed the issue under investigation, a review of the legislative developments in these states will follow. Cases in which the Board of Medicine has rendered action against practitioners will be discussed. Next, the opinions of the citizens of the Commonwealth of Virginia will be summarized. And, finally, potential policy options will be presented.

Summarization of Target Article

The target article describes the inception and early history of the Office of Alternative Medicine (OAM) at the National Institutes of Health beginning in 1992. The initial funding for the OAM came as a result of the efforts of current Iowa representative Tom Harkin whose friend, former Iowa Representative Berkeley Bedell, was reportedly cured of Lyme Disease and prostrate cancer through unconventional treatments; both are in remission as a result of alternative treatments. The committee that oversees the NIH budget reported dissatisfaction with conventional medicine's approach to evaluating the efficacy of unconventional medical practices.

Shortly after the inception of the OAM, The New England Journal of Medicine (1993) published a study that enumerated descriptives concerning the use of alternative medicines in the American population. Eisenberg et al., (1993) reported that one-third of Americans use some form of alternative/unconventional therapy for illness. This consumption accounts for 14 billion dollars. Americans visited more alternative health care providers than all primary care physicians combined to a tune of 425 million to 388 million. However, the authors caution the reader that these numbers include therapies such as weight loss programs, physical fitness routines, relaxation, etc.: therefore suggesting that this enumeration may be inflated.

The OAM initially consisted of an Executive Director, Joe Jacobs, and a two million-dollar budget. Many problems faced this fledgling institution, the most prominent of which concerned both defining and evaluating unconventional therapies. Dr. Jacobs employed the help of statisticians, scientists, and health administrators to address these issues. The OAM initially defined unconventional therapies as those treatments not widely taught in U.S. medical schools or available at most hospitals.

The OAM faced many obstacles to acceptance. Among these was the long history of medical quackery in this country. The government enacted the Pure Food and Drug Law of 1906 in an attempt to reduce the incidence of fraudulent therapies. Although many of the treatments earmarked for investigation had centuries of anecdotal support, many conventional practitioners long viewed alternative therapies as quackery. In addition, traditional practitioners viewed the perpetuators of these treatments as unprofessional. As a result, many alternative practitioners were forced to keep their practice a secret. Faced with an air of distrust, Jacobs began a mission to evaluate these treatments. He believed that it was his duty to support research involving alternative treatments, and in turn, to publish the results for public scrutiny.

Surprisingly, opposition to this research came not only from the traditional medical establishment but also from alternative practitioners. Apparently, cult-like ambiances surrounded many alternative therapies because of their clandestine histories. As a result, some alternative practitioners also voiced oppositions to investigative research in their field.

In the first year, the OAM awarded 30 projects, $30,000 each for one year. The projects supported by the OAM ranged from acupuncture to t'ai chi. Expectations resulting from the outcome of these initial studies seemed reasonable. Jacobs viewed these as pilot studies that would outline the directions for future research. Since its inception, the OAM has received increasing budgets as public opinion has emerged in support of its mission.

What Are Unconventional Therapies?

The OAM defines unconventional and alternative therapies as those treatments not widely taught in U.S. medical schools or available at most hospitals. Note that defining alternative treatments is a very difficult task. Many definitions of alternative treatments have been proposed; hence studies investigating alternative treatments must be interpreted with this in mind. The OAM divides alternative treatments into seven categories so as to expedite research and the grant review process. These seven divisions are neither exhaustive nor mutually exclusive. The OAM cautions the individual not to view these as definitive.

Diet, Nutrition, and Lifestyle Changes comprise one category. Included in this group are therapies such as megavitamin therapy, macrobiotic diets, changes in lifestyle, and diet programs.

A second division of alternative medical practices concerns Mind/Body Control. Some of the elements that comprise this division are licensed and accepted as traditional treatments for some diseases; however, the use of these techniques to treat medical disease is considered unconventional. This division includes psychotherapy, biofeedback, support groups, prayer, and hypnotherapy.

Systems of medical practice that have rich histories in other countries but which experience little acceptance in traditional Western medical circles are grouped in the Alternative Systems of Medical Practice division. These practices include acupuncture, homeopathy, and shamanism.

Manual Healing comprises the next class of alternative treatments. This category includes forms of treatment where the primary mode of healing is through touch. These systems include chiropractic medicine, massage therapy, acupressure, and reflexology

Treatments that specialize in blood and blood product purification are classified as Pharmacological and Biological Treatments. These include chelation therapy, ozone infusion, and cell treatment.

Bioeletromagnetic Applications include treatments such as artificial lighting and electroacupuncture.

The OAM's final division is Herbal Medicine. This classification includes herbal preparations. Some of the herbs and preparations of interest are echinacea, ginseng, garlic, gingko biloba, and Essiac.

Over the last 20 years, the popularity of alternative medical treatments has immensely increased among medical patients (Eisenberg et al., 1993; Himmel et al., 1993;

Siano, 1994). Researchers have given many reasons to account for this increase. Among these are: distrust of the medical establishment (Furnham, 1988; Siano, 1994); dissatisfaction with current remedies (Abrams, 1990; Barton et al., 1989; Donnelly et al., 1985; Furnham & Smith, 1988; Himmel et al., 1993); synergistic effect with conventional or traditional medical treatments; and reduction in drug toxicity side effects (Abrams, 1990).

Eisenberg et al., (1993) conducted a national survey in which they discovered that, on average, 1 in 3 respondents engaged in some form of alternative therapy in the preceding twelve months. Additionally, they discovered that 1 in 4 people who visit a traditional physician for a serious health problem also visit an alternative practitioner. This study demonstrated that alternative treatment use is pervasive in all socioeconomic groups.

Furman and colleagues (1988; 1993; 1994; 1995) have conducted several studies investigating the reasons why people choose to visit alternative practitioners. Additionally, they have investigated differences in attitudes and beliefs between individuals visiting general practitioners and those visiting alternative practitioners. These authors have found that people who visit alternative practitioners are generally more skeptical about the efficacy of modern medicine. Furthermore, these individuals believe that they have increased control over their health relative to their peers (also Suarez & Reese, in preparation). As a result, these people generally engage in more health promoting activities such as exercise and proper nutrition. Essentially, alternative treatment users believe that "disease" is a *dis*-ease which involves the physical, mental, spiritual, and emotional aspects of the individual (Hay, 1987). Other characteristics of this population include increased confidence in their chosen practitioner and decreased psychiatric morbidity (Furnham & Smith, 1988; Furnham & Bhagrath, 1993).

Research and acceptance within the conventional medical community has been sparse. However, the AMA has stated that these therapies deserve evaluation. After all, some of our most common medicines were derived from natural substances, for example aspirin. Additionally, many well known medical schools are beginning to offer courses in alternative and complementary medicines (see the Appendix).

The major objections from the scientific community concern the safety of these treatments (Ernst, 1995). Even if proven effective, these treatments are not unlike traditional treatments; wrongly applied, they can be harmful. For example, herbal preparations may be toxic, cause deleterious interactions, or contain potent metabolites or heavy metals (Ernst, 1995). Other therapies (e.g., manipulative treatments) can cause serious or fatal complications (Frisoni, 1991). Many alternative treatment supporters argue that the lack of evidence of risk for harm is proof of safety; however, the absence of evidence for harm should never be misconstrued to be a true absence of risk (Ernst, 1995).

Concern for safety is exacerbated by the perceived lack of training for alternative practitioners (Campion, 1993; Ernst, 1995). Many traditional M.D.'s believe that alternative practitioners lack proficiency in biology, chemistry, anatomy and other courses essential for diagnosing disease. Misdiagnosis can be harmful or even fatal. Even if treatment efficacy is established, proper application and diagnosis is pertinent to maintain the safety standards applied by traditional medicine (Ernst, 1995).

O'Neill (1994) identifies three "risk of harm" areas for alternative treatments: (i) sins of omission in diagnosis, (ii) intrinsic procedural risks, and (iii) situational amplifications in which symptoms are exacerbated. The author continues that scientific or confirmatory trials are rarely conducted on modalities used by these practitioners. Additionally, many treatments are embraced solely on anecdotal evidence. They then gain widespread use without adequate validation. O'Neill cautions that acceptance of these treatments can come only through legal or medical channels. Since medicine has been unhurried in validating these treatments, legal actions have been propagated by vocal self-interest groups.

Legislative Reform in Other States

As of March 1996, six states have enacted laws that directly protect the alternative medicine practitioner from license revocation solely for practicing unconventional forms of medicine. Additionally, 12 other states have pending legislation in which alternative or unconventional therapies are addressed. A seventh state, Arkansas, has enacted an "Any Willing Provider" law. Further discussion of this law will follow. Acts from all seven states will be reviewed in detail. Note that all attempts have been made to conduct an exhaustive review of current legislative developments; however, many states are of late considering legislation concerning alternative treatments. Therefore, recently proposed legislation may not be incorporated here.

Enacted Legislation

Alaska: In 1990, the state legislature of Alaska amended their malpractice law to incorporate alternative modalities. This amendment limited the acts that the Board of Medicine could select when determining the course of action for alternative medicine practitioners. The amendment protects medical practitioners from legal recourse "if the treatment provided was recommended or warranted by the facts known to the person, board, or peer review committee." The law explicitly states that "the 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 physical harm to the individual." Under this law, it would appear that the Board would be required to demonstrate that actual physical harm occurred in order to prove incompetence: regardless of the predetermined effectiveness or intrinsic risk of the therapy (Sale, 1994). The Division of Occupational Licensing denied conducting research as to the plausibility of the enacted legislation. According to this Board, a vocal minority proposed and pushed through the amendment.

Washington: In 1991, the State of Washington followed suit with its own statute. The amendment to their Uniform Disciplinary Act stated that the "use of nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create unreasonable risk that the patient may be harmed." The law in this state gives the Board more latitude to discipline practitioners relative to the Alaska Board. The reference to "unreasonable risk" gives the state the ability to perform a risk assessment to determine the danger of physical harm.

North Carolina: In 1993, the state legislature of North Carolina amended their Medical Practices Act to incorporate the practice of complementary medicine. As in Alaska, this law prohibits the Board of Medical Examiners from revoking the license of a physician solely for practicing alternative therapies. The exception is, however, that the Board can revoke a physician's license if it can "establish that the treatment has a safety risk greater than the prevailing treatment, or that the treatment is generally not effective." Essentially, this law protects alternative medical practitioners from being charged with unprofessional conduct for practicing therapies that are experimental, nontraditional, or that depart from prevailing medical practices. This law now places the burden of proof on the Board to demonstrate negligence or harm. As in Washington, this law gives the Board more leeway in disciplining alternative medicine practitioners.

South Dakota: The law enacted by the South Dakota State Legislature in 1993 is the only law that specifically names an alternative treatment modality. This law states that the Board shall not base a finding of unprofessional or dishonorable conduct solely on the basis that the licensee practices chelation therapy (Sale, 1994).

New York: In 1993, New York began enacting a series of amendments that granted alternative medical practitioners protection under the law. The last of these laws was enacted in 1994. These amendments to the Education Law state that "physicians can make use of whatever medical care, conventional or non-conventional, which effectively treats human disease, pain, injury, deformity or physical condition." Additionally, this law requires that "of the eight physicians on the state medical board, no fewer than two must be physicians who dedicate a significant proportion of their practice to non-conventional medical treatments." It is stated in the amendment that the New York State Medical Association is committed to the advancement of such treatments and recognizes the legitimacy of such forms of medicine.

Two cases have arisen in which implementation of this law has occurred. First, New York revoked the license of a physician already under disciplinary action in another state for fraudulent billing, excessive overcharging, making false representations, record keeping violations, and the use of experimental treatments (Matter of…, 1995). Again, he was charged with the above findings, with the exception of implementing experimental treatments. This physician no longer has a license in New York. The second case involved a physician who was charged with promising a cure for multiple sclerosis, billing excessively for a novel treatment of his own making which lacked evidence of efficacy,

failing to provide the level of care promised to his patients, and in some cases, abandoning his patients (Matter of…, 1995). This physician was appropriately disciplined without infringing on the rights of his patients (Miller, 1996).

Oklahoma: Oklahoma also enacted legislation in 1994 that protected alternative medicine practitioners. The state legislature of Oklahoma amended their Medical Practice Act to read "the Board shall not deny license to a person otherwise qualified to practice allopathic medicine … solely because the person's practice or therapy is experimental or nontraditional." Additionally, the law prohibits the Board from revoking the license of duly qualified practitioners solely because the physician practices an unconventional or experimental therapy. Unlike the other medical practice acts that accommodate the practice rights of alternative physicians, this law does not specify the conditions under which the Board may take disciplinary action against a licensee (Sale, 1994).

Arkansas: In 1995, Arkansas became the first state in the Union to pass an "Any Willing Provider Law." This law explicitly requires managed care organizations to accept to their network any willing provider who meets their terms of service. Although the law is broad, it does limit inclusion to the following: medical doctors and osteopaths, podiatrists, chiropractors, physical therapists, speech pathologists, audiologists, dentists, optometrists, hospitals, hospital based services, psychologists, licensed professional counselors, respiratory therapists, pharmacists, occupational therapists and long-term care facilities, home health care and hospice care, licensed ambulatory surgery centers, and rural health clinics. This law implies that a health maintenance organization (HMO) must accept a practitioner to its network if this practitioner meets the HMO's service terms: regardless if the provider practices alternative medicine.

Oregon: Oregon, in 1995, passed a law similar to those passed in North Carolina, New York, and Alaska. This law states that "alternative medical treatments shall not by itself constitute unprofessional conduct." This act protects practitioners if they are practicing any therapy from which the "professional has objective basis to believe in the treatment's efficacy even if the treatment is apart from recognized science or standard treatment, or lacks approval of the United States Food and Drug Administration." As with the law enacted in Oklahoma, the conditions by which the Board can revoke a license were not stated. This law requires that the physician have objective proof of the treatment's efficacy. However, if the proof can be of a personal nature, then that proof by definition is subjective. The law was enacted through a legislative override of the governor's veto.

Arizona: In 1995, Arizona extended the Naturopathic Physicians Board of Medical Examiners. They narrowed the scope of Homeopathy, and broadened the definition of homeopathic practice.

Note these laws do not protect all alternative medicine practitioners from recourse, rather they only pertain to individuals who come under the jurisdiction of the Boards in

their respective states. In summary, these laws have been enacted to protect alternative practitioners from Board action solely because the treatment(s) prescribed was unconventional. However, these laws still hold the physician accountable for harmful treatments.

Pending Legislation

Some of these synopses were obtained from the Public Report: 1995/96 Medical Freedom Legislation in the States. Published by the Foundation for the Advancement of Innovative Medicine.

Massachusetts: In 1995, Massachusetts put in "study order" a bill that, according to comment from the Board of Medical Examiners, would have all but removed the power of the Board to regulate physicians. The law read that "No agency of the Commonwealth shall interfere with the medical practice of a duly qualified practitioner of the medical arts because such practitioner engages in a form of the medical arts which is not considered standard or orthodox practice by prevailing standards absent the finding that any such practice represents a direct threat to the life or health of the patient."

California: California proposes to add unconventional physicians to the Division of Medical Quality. The proposed law would allow for the use of unconventional treatments and deny license revocation solely for its use. The proposed law also requires informed consent to be obtained prior to treatment initiation.

Kentucky: Kentucky proposed passage of a law which would allow for unconventional treatments to be administered when there is a reasonable expectation of efficacy. In addition, the proposed law would allow for more fair peer review.

Louisiana: Louisiana proposes to prohibit the Board of Medical Examiners to refuse issue, suspend, or revoke licenses solely based on alternative or unconventional treatments.

Maine: The Governor of Maine has appointed a panel to make specific recommendations concerning the licensure of Naturopathic medicine.

Missouri: Missouri has proposed a law similar to North Carolina, New York, and others. This law would prohibit state boards or agencies from interfering with a licensed practitioner for practicing unconventional treatments.

Nebraska: Nebraska has proposed an insurance law which would "define medically necessary care to mean medical intervention; diagnostic, preventive, prophylactic, ameliorative, curative, or quality-of-life care which is indicated by the presenting problem, appropriate examination, history, and tests, and is supported by a thorough consideration of the treatment options available and a reasonable expectation of

efficacy, and is in keeping with consent of the patient, and is not strictly cosmetic" (Miller,1996).

New York: New York is considering enacting insurance laws similar to Nebraska. However, New York is additionally proposing to mandate coverage for experimental/investigational treatments, and non-approved uses of FDA approved medicines.

South Carolina: South Carolina proposes to add unconventional physicians to the Board of Medical Examiners. In addition, they would add unconventional practice to the definition of physician surgeon.

Texas: In the previous legislative session, Texas killed an amendment which would have disallowed the Board to base findings solely on the auspices that the treatment was unconventional in the absence of harm.

Vermont: Vermont proposes to establish an advisory committee to the Office of Professional Regulations. This committee would advise on matters of, and licensure of, Naturopathic physicians.

Wisconsin: No information available.

Disciplinary Action

It is appropriate in this section to discuss disciplinary actions taken by the Virginia Board of Medicine on physicians practicing alternative medical treatments. Four case histories are reviewed with respect to case specifics and disciplinary action taken. Note that this was not an exhaustive review.

On April 7, 1982, the Board of Medicine reinstated the license of a Doctor of Chiropractic reprimanded for dispensing nutritional supplements and diagnosing yeast infections without accepted therapeutic purpose. Two patients of this chiropractor filed complaints questioning his therapeutic modalities. Complaints centered on the diagnosis of systemic yeast infections by means of placing a yeast pill either inside the mouth or on the body's surface. Comment from the Board concerned defective methodology. The chiropractor failed to document his therapies in ways that would allow for scientific rigor. In addition to license suspension, the Board required that the chiropractor attend monthly educational programs. The Board also restricted the chiropractor from using applied kinesiology as a nutritional diagnostic modality, from treating or purporting to treat systemic yeast infections, and from selling nutritional supplements.

On December 23, 1992, the Board of Medicine indefinitely suspended the license of a physician who, on numerous occasions, indiscriminately administered injections of vitamins and other substances into his patients. The Board deemed these practices

contrary to sound medical judgment. Again, the Board opposed the record keeping and methodology of this licensee. In addition, this doctor failed to receive informed consent from his patients prior to initiating treatment. The referred to physician is under order to notify the Board prior to resuming practice. The Board imposed additional sanctions; however, these are moot because the doctor no longer practices in the Commonwealth of Virginia.

On December 5, 1995, the Board of Medicine voted to continue on indefinite probation a physician charged with 13 counts of medical malpractice. As with the other doctors disciplined by the Board, his treatments were without accepted therapeutic purpose. The methodology of this practitioner involved an immune alteration therapy incorporating autogenous vaccines derived from urine or stool samples. This physician failed to obtain informed consent from his patients. Additionally, he failed to inform his patients of the experimental nature of these therapies. Again, the Board disagreed with the documentation of these questionable procedures. The Board decided to continue his probation because this practitioner has failed to comply with the terms of the Board.

On March 19, 1996, the Board of Medicine voted to hold an informal hearing to determine what action(s), if any, to impose against a physician who is currently on indefinite probation. The Board previously found this practitioner's treatments to be without accepted therapeutic purpose. Like the other disciplined practitioners, this physician failed to keep appropriate records. The Board also charged this physician with failure to rely on scientific diagnostic and objective findings in establishing a diagnosis, failure to investigate patients' medical histories, and failure to consider possible drug side effects. By his own admission, this physician has failed to cease performing said treatments. In addition, he has failed to keep accurate records.

The Board disciplined these doctors for prescribing treatments without accepted therapeutic purpose. Although these treatments were unconventional, the Board's concerns were only tangentially related to this issue. The main arguments of the Board centered around the lack of methodological considerations of these physicians. Note that action from the Board followed written complaints from the physicians' patients.

Public Comment

Public comment from the citizens of Virginia was solicited on two occasions. The initial solicitation, requested between August 15, 1995 through March 15, 1996, sought to inform the Board generally about the topic area of the practice of alternative/complementary medicine and its relationship to the laws governing the delivery of health care in Virginia. The second request was made to receive comment on the draft report of the Board's review and covered the period of April 16 to June 15, 1996.

In response to the first request, a total of 110 responses were received from citizens of the Commonwealth. Of these 110, all but one comment was recorded as

support for alternative therapies. Fifty-four responses were recorded as supporting legislation that would allow citizens of Virginia the freedom to choose their medical care practitioner. Sentiment in most of the comments reflected enacting laws similar those passed in New York, North Carolina and Alaska. Public comment was received from 33 citizens who were against any legislation that would prevent their access to alternative medicine practitioners. Additionally, 29 individuals expressed support for alternative therapies; however, no opinion was rendered as to the support or nonsupport of laws concerning alternative treatments.

Only one comment received was adamant in regulating alternative practitioners. This comment was hostile towards chiropractors, yet, in the same instance, supportive of massage therapists. This citizen recounted the experiences that she had while in the care of a chiropractor. Her main argument centered on disallowing non-MD's to represent themselves as Doctors or Healers. She felt that allowing non-MD's to do that would cause harm to their unsuspecting patients. Additionally, she expressed concern for increasing insurance premiums if non-MD's are allowed to practice and bill for their services.

The initial solicitation for public comment attempted to determine: (i) obstacles to obtaining alternative medical treatments in the Commonwealth of Virginia; and (ii) injury due to alternative medical practices. Although the majority of public comment did not address these issues, a select few did. The majority of public comment centered on treatments used and satisfaction with these treatments. The following list summarizes comments that addressed limitations to access:

Lack of alternative medicine practitioners in the Commonwealth due to an unattractive legal climate
Lack of insurance reimbursement
Lack of advertisement of alternative medicine practitioner for fear of retaliation
Negative attitudes from allopathic practitioners

In response to the second request for public comment, 27 letters were received. The pattern of responses was similar to that received earlier. Nineteen wrote in favor of policy to support alternative/complementary medicine. Five voiced opposition. Two noted concern over the misspelling of "complementary."

Of those in favor, six respondents voiced their general support of alternative practices (i.e., chelation, homeopathy, chiropractic) and their hopes that the availability of alternative practices would not become curtailed. One noted that she had to travel many miles to reach a licensed practitioner. Some reported concern about the chilling effect of biases against alternative/complementary practitioners from other health care providers (8), from third-party payors (3), from regulatory boards (2), and from the U.S. health care system in general (1). And, seven commenters called for legislation similar to that passed in New York, Alaska, North Carolina and other states which disallows sanctioning solely

on the basis of employing alternative/complementary methodologies.

Those in opposition cited safety concerns, the relative lack of scientific proof of efficacy, and a concern that established health care may lose already depleting public health care dollars in favor of alternative/complementary medicine.

Summary and Conclusions

The presented work summarizes the current state of affairs with alternative medical practices. Scientific investigation into these modalities has just begun to become important. Alternatively, legislative developments have occurred rapidly. Seven states have enacted legislation which affects alternative practitioners, and 11 other states are considering legislation.

Scientific comment primarily pertains to the safety issues of these treatments. However, it appears that public opinion is highly supportive of these modalities: or at least the freedom to choose these modalities. Citizens of the Commonwealth overwhelmingly voiced their support for either (i) enacting laws protecting their freedom to choose appropriate medial care, or (ii) forgoing legislation that would hinder access to practitioners of their choosing.

The main hindrances to accessing these treatments concern either the lack of availability of the treatments, or the lack of reimbursement. Negative attitudes from traditional practitioners and an unattractive legal climate are reasons voiced for these hindrances.

Policy Options

The information presented in this review and the attendant public comments provided for the following policy options. Though not exhaustive or mutually exclusive, the options were tailored to provide for a relatively broad selection of approaches to address the issues described in the study:

1. Recommend legislation to better assure the public's access to alternative/complementary medicine.

Legislation may provide for better access through several means. The following two ideas are examples.

Lack of third-party reimbursement has been cited as a barrier to the access to alternative/complementary practice. "Any willing provider" legislation, such as that adopted last year in Arkansas, may increase the availability of practitioners in Virginia who are otherwise licensed.

Another means of increasing potential providers would be to increase the availability of training programs in the Commonwealth. Expansion of existing programs and development of future programs could be proposed.

2. Exempt the practice of alternative/complementary medicine from any state regulation.

Also related to providing better access would be legislation which would effectively exempt the practice of alternative/complementary medicine, per se, from state regulation. The respective health regulatory boards would continue to monitor service to ensure its safe and effective delivery by their respective licensees.

The discipline of practitioners of alternative/complementary medicine in the Commonwealth has not focused on the use of alternative/complementary methodologies, per se. Nevertheless, public comment points to fear of Board discipline which they contend has had a chilling effect on practitioners who may wish to employ unconventional approaches, effectively barring the public from receiving such intervention.

Thus, to ameliorate the fear and, thereby, potentially increase the number of practitioners who would be willing to provide alternative approaches, legislation could be proposed, such as that already passed in other states which would prohibit regulatory boards from sanctioning licensees solely because they have used alternative methodologies. Unconventional treatment methodologies could be used if the patient is informed, the approach is adequately recorded in patient records, the treatments and results are carefully monitored, and the patient's safety is safeguarded – no different than the standards for any other type of practice.

3. Recommend legislation providing for registration of providers of alternative/complementary medicine who are not otherwise licensed.

The relative lack of consumer protection against nonregulated practitioners has been noted as a concern by both proponents and opponents of alternative/complementary medicine. One solution would be to propose legislation which would allow for the registration of those practitioners who wish to be recognized as practitioners of alternative/complementary approaches but who are not otherwise licensed. This should somewhat satisfy those who resist governmental restraint on practice and those who seek some avenue for consumer protection

Registration is the least restrictive form of occupational regulation. It generally requires only that a practitioner register with the state. No standard is

imposed on those who desire to register to perform a service. However, if a consumer seeks redress against the registrant, identifying information is on file with the state, and there can be a means to remove his name from the registry for cause.

4. Recommend that no action be taken.

The Board may decide to recommend that no legislative or regulatory action be taken. Sufficient justification may not be considered to have been demonstrated. The Board may choose to consider the following:

- **Alternative/complementary medicine is being practiced and many individuals have access to it**. It may not be optimally accessible, but it is available.

- **Educational programs do exist in medical schools and other health training programs which provide for training in alternative/complementary approaches.** These programs are new, some consisting of a single course, but they are available.

- **No legislative or regulatory barriers exist which make the practice of alternative/complementary medicine, itself, by licensees illegal.** There may be concern that some practitioners of alternative/complementary medicine have been disciplined by the Board for matters involving unconventional practice, but no one has been sanctioned because he was practicing alternative/complementary medicine.

- **Third-party payment is available for some forms of alternative/complementary practice.** While some public comment has indicated that lack of third-party payment to practitioners of alternative/complementary medicine poses a barrier to access, there are practitioners who do receive reimbursement through insurance. For example, chiropractors and physician acupuncturists generally may bill directly and even licensed non-physician acupuncturists may do so upon referral.

The Board concluded that the current state of alternative/complementary medicine is encompassed by a wide range of complex issues which cannot be adequately addressed through policies resulting from any single study. Therefore, the Board rejected the above options, and concluded that, at this point in the evolution of the field, the most effective policy is that directed toward fostering a better understanding of the issues by the affected parties -- consumers, practitioners, third-party payors, and the public in general. To that end, the Board offers the following final recommendation.

Final Recommendation

The Board of Health Professions recommends that the General Assembly may wish to consider sponsoring an educational effort to share information on alternative/complementary medicine for the purpose of education regarding the practices of and access to alternative/complementary medicine.

In terms of fiscal impact, the cost of such an effort is estimated at approximately $20,000 for speaker honorariums, materials development, printing, publication of meeting notices, and so forth. As is typical with other symposia, the associated expenditures could be recouped by a participant registration fee.

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APPENDIX

Medical Schools Offering Courses in Alternative/Unconventional Treatments

Albert Einstein College of Medicine

Boston University School of Medicine

Case Western Reserve School of Medicine

Columbia University College of Physicians and Surgeons

City University of N.Y. Medical School

Emory University School of Medicine

Georgetown University School of Medicine

Harvard Medical School

Indiana University School of Medicine

Jefferson Medical College of Thomas Jefferson University

Johns Hopkins School of Medicine

Medical College of Pennsylvania

Mount Sinai School of Medicine

New York Medical College

Ohio State University College of Medicine

Stanford University School of Medicine

SUNY at Buffalo School of Medicine

Tufts University School of Medicine

Uniformed Services of the Health Sciences

University of Arizona School of Medicine

University of California, Los Angeles School of Medicine

University of California, San Francisco

University of Cincinnati School of Medicine

University of Louisville School of Medicine

University of Maryland School of Medicine

University of Miami School of Medicine

University of North Carolina Chapel Hill School of Medicine

University of Virginia School of Medicine

Wayne State University School of Medicine

Yale University School of Medicine

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

VIRGINIA BOARD OF HEALTH PROFESSIONS

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NOTE: This report was prepared for the Board of Health Professions under contract with Troy Suarez, M.S.