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10/3/03
Date

2003 HOUSE HUMAN SERVICES

HB 1376

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2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1376

House Human Services Committee

☐ Conference Committee

Hearing Date February 10, 2003

Tape Number	Side A	Side B	Meter #
1		x	6.8 - 56.2
Committee Clerk Signature Sharon Renfrew			

Minutes:

Rep. Wrangham appeared as prime sponsor with written testimony.

Dr. Brian E. Briggs appeared in support with written testimony

Rep. Weisz: looking at the language at this bill, assuming you have a therapy that's not necessarily successful but its not causing physical harm, but if that would prevent a patient from using established therapy, would that still fall under this language or is harm being done to the patient? I'm interested as to how you interpret that language "absent demonstrable physical harm to a patient", Assuming you have a therapy that's not necessarily affective, but its not harming the patient, but if it prevents him from other care, is that causing harm to the patient under the definition in this bill, how would you interpret that as a doctor?

Answer: I don't think that any doctor can operate in a situation where he is causing harm to people and expect to be protected by any law.

Richard Hammond appeared in support with written testimony.

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Rep. Ruby appeared and acknowledged his support on this bill referencing the bill last session in regard to layatril and removement of treatment for cancer. Feels this bill is somewhat of a companion of that and thinks it cleans up and clarifies the use of treatments that are considered somewhat alternative.

Ruth Schell appeared in support with written testimony.

Rep. Price asked that if she was already receiving the treatments from Dr. Briggs and there hasn't been a problem, do you feel the bill is necessary? Answer: I do not want to see something come along later on that would stop us from having these treatments.

Clayann Almquist appeared in support with written testimony.

Constance Briggs, appeared in support with written testimony.

Rolf Sletten, Director of the State Board of Medical Examiners appeared in opposition with written testimony.

Rep. Price, mentioned that the opponents stated there were 9 states that have language as far as alternative therapies and asked Mr. Sletten if he was aware of them. Answer: No

Rep. Niemeier asked if Dr. Briggs had a current valid license to practice in ND? Answer: Yes

Rep. Potter asked that if chelation therapy is being done, is that supposed to be against the rules or is Dr. Briggs getting in trouble with here.

Answer: We can't tell, what is it they want to do that they can't do under the current law now?

Rep. Weisz: What does the Board do, do they do an individual assessment for any practice or therapy that might come before you? Answer: yes

David Peske of the ND Medical Assoc. appeared in opposition stating they feel acupuncture, vitamins, etc. are being incorporated into many practices today.

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Rep. Porter: mentioned the alternative therapy that's being incorporated into practices today are researched based and typically been looked at from large research case facilities prior to moving out into the mainstream general practice. The way I read this bill, that would take that research base alternative medicine particularly away from the research facilities and someone could just start doing what they wanted to. Answer: Feels that's an accurate interpretation.

John Olson, serves as the Special Assistant for the Attorney General to the ND Board of Medical Examiners appeared in opposition stating the language that appears before in the bill, although we believe is not needed would also cause confusion and a lot of interpretations I perfect in the Court. I know what it says, it seems to say that unless there is actual harm, injury or death to a patient caused by the alternative care, we cannot bring a prosecution when we are not for sure about Rep. Weisz' question "what would happen if that therapy didn't cause harm" however the lack of the other perhaps conventional treatment was necessary and the fact that the patient didn't get it and resolved in the injury or death to that patient. That's a real troublesome question and I can't tell you which way the court would go on that, but I can tell you this, that we expect physicians, regardless of how expert they are in a particular specialty, when a patient comes to them, and wants the services of that physician and the physician cannot help them or perhaps only has one remedy available for that patient, we expect that physician to give that patient a range of options. That's part of general excepted medical practice.

Closed the hearing.

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2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1376

House Human Services Committee

☐ Conference Committee

Hearing Date February 11, 2003

Tape Number	Side A	Side B	Meter #
1	x		23.7 - 30.9
Committee Clerk Signature			

Minutes: Committee Work

Rep. Wieland stated he doesn't see any reason for this bill and doesn't see any problem here or that no action was brought against Dr. Briggs. He was the only one who testified and we aren't protecting regular doctors, doesn't see why we should be doing any singular protection and made a motion for DO NOT PASS, second by Rep. Potter.

Rep. Potter noted that people have gotten very good care from doctors like these and would like to go on record as saying that I do think that they do have a point that aren't listened to and are ostracized.

Rep. Price asked if she was aware of any of the two physicians being prohibited from practicing by the Board of Medical Examiners?

Answer: I know that the Board of Medical Examiners has made life very difficult for them.

Rep. Uglem commented that he feels we have an awful lot to learn and its probably true, this medical field puts everybody at arms length if there's something different and feels there are a lot

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of good things out there but there is no way we can support this bill with absent demonstrable physical harm.

VOTE: 11 - 0 - 2 Rep. Wieland will carry the bill

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Date: 2.11-03
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB ~~1123~~ 1376

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number ______

Action Taken DNP

Motion Made By Rep Wieland Seconded By Rep Porter

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig	✓	
Rep. Bill Devlin, Vice-Chair	✓		Rep. Bill Amerman	✓	
Rep. Robin Weisz A			Rep. Carol Niemeier A		
Rep. Vonnie Pietsch	✓		Rep. Louise Potter		
Rep. Gerald Uglem	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Gary Kreidt	✓				
Rep. Alon Wieland	✓				

Total (Yes) 11 No 0

Absent 2

Floor Assignment Rep Wieland

If the vote is on an amendment, briefly indicate intent:

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[signature] 10/3/03
Operator's Signature Date

REPORT OF STANDING COMMITTEE (410)
February 11, 2003 11:25 a.m.

Module No: HR-26-2249
Carrier: Wieland
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HB 1376: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (11 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). HB 1376 was placed on the Eleventh order on the calendar.

(2) DESK, (3) COMM

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Donna Galbraith 10/3/03
Operator's Signature Date

2003 TESTIMONY

HB 1376

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Madam Chair Price
members of the Human Services Committee

HB 1376

The good news - this bill doesn't require an appropriation!
It merely gives our citizens freedom to choose.

~~This bill~~ HB 1376 is part of the trend in health care to allow patients to select alternative therapies for many medical conditions. This bill is part of a joint effort between consumers and practitioners to promote what is called "Medical Freedom Legislation". Presently, nine states have passed some form of Medical Freedom Statute. They are: Alaska, Colorado, Georgia, New York, North Carolina, Oregon, Oklahoma, South Dakota, and Washington. Similar legislation is pending in 13 other states. This bill provides necessary guidance for the State Board of Medical examiners in the use of their authority to regulate physicians and surgeons. Today, patients should be free to choose from a wide variety of treatments for any condition. When there is no harm to the patient, the State Board of Medical Examiners should have no authority to regulate the practice. This bill simply makes this reasonable principle a statutory requirement.

We have, present today, citizens who have much more experience + expertise is this area. ~~Please~~ I am sure they are better versed and able to answer your questions than I am.

However, if you have any questions for me I will try to answer them.

Thank you!

Testimony by
Representative Dwight Wrangham

2-10-03

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[signature]
Operator's Signature

10/3/03
Date

HOUSE BILL NO. 1 376

February 10, 2003

Madame Chairwoman, Committee Members, and interested fellow citizens:

I am Dr. Brian E. Briggs, MD of Minot, ND here to speak in support of H.B. 1376 to amend and re-enact subsection 21 of section 43-17-31 of the North Dakota Century Code.

Those supporting this Bill need to convince you of the need for such action. When I first started practicing medicine in North Dakota almost 50 years ago, I remember hearing comments from older physicians regarding the status of medicine as practiced in the United States. The essence of the comments was that American medicine is the best in the world, but it is expensive.

I had no reason to doubt that kind of statement until after I had started to enter ranks of alternative physicians in the early 1970's. Even then I tended to consider the complaints against the medical establishment as sour grapes. The most convincing evidence, however, came in 1988 when the People's Medical Society published their book Medicine on Trial The Appalling Story of Medical Ineptitude and the Arrogance That Overlooks It, which presented cases and statistics from mainline medicine to prove their position. Since then the evidence continues to grow regarding the high cost and gross deficiencies of healthcare in the United States.

In your packets, which I have provided, you will notice that Pages 2 & 3 are a summary of the studies done by Barbara Starfield, MD, MPH of the Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health. Her work was published in the July issue of JAMA, July 26, 2000. In the top half of this report you will find almost incredible charges such as:

20-30% OF PATIENTS RECEIVE CONTRA-INDICATED CARE.

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44,000 – 98,000 DEATHS/YEAR DUE TO MEDICAL ERRORS.
US RANKS AN AVERAGE OF 12TH FOR 16 AVAILABLE HEALTH INDICATORS.
WORLD HEALTH ORGANIZATIONS MAKES US 15TH
ON THE SECOND PAGE MORE DEATHS DUE TO MEDICAL FAILURES ARE RECORDED AND ARE ESTIMATED TO TOTAL OVER 200,000 PER YEAR WITHOUT COUNTING SERIOUS DISABILITIES. 225,000 DEATHS WOULD CONSTITUTE THE 3RD LEADING CAUSE OF DEATH.

I encourage you to read the entire report when you have time after the legislative session as well as our patient booklet which we are providing each committee member. You will then have some idea of how preventive medicine is applied to patient situations.

Page 5 is a newsletter that came with the monthly meeting report from the Arizona Homeopathic and Integrative Medical Association. Read paragraph one where a New England Medical Journal cited a report showing that of 1000 patients who were advised to have cardiac surgery, mortality was 210% greater with those who received it than those who refused. In other studies medical treatment results in 1% morality/year.

When I was placed on probation for doing alternative therapies in 1983 for five years, I was told that I could do anything that was taught at the Medical School in Grand Forks. Two years later UND Medical School published in their quarterly News Review an article on "Teaching Medical Ethics" that is reprinted on your pages 7 to 9. Turn to page six and read at least those underlined sentences which state, in essence, that a doctor has a responsibility to do for each patient whatever is needed to bring about release from pain or healing from disease without regard, necessarily, to what general measures might be recommended in a current therapy manual. Page 10 has a few articles listing some states that have passed legislation to provide freedom of choice in medical care for patients, but in many cases that doesn"t help the doctors who are interested in providing it. If the medical establishment continues to ignore and fight alternative therapies, then they will have to continue doing hazardous treatments in doubtful cases (unnecessary surgery, for instance) and accept the increasing in-hospital death rates along with the falling world rank. The patients do not want either!

Respectfully Submitted,
Brian E. Briggs

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(2)

MORE EVIDENCE ACCUMULATING ON THE DEFICIENCIES OF HEALTH CARE IN THE UNITED STATES

In the July 26, 2000 issue of JAMA (Vol. 284, No. 4) Barbara Starfield, MD, MPH of the Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health, talks about the deficiencies of U.S. medical care. Among her notes and comments are:

- More than 40 million people have no health insurance.
- Evidence from a few studies indicates that 20 percent to 30 percent of patients receive contraindicated care.
- An estimated 44,000 to 98,000 die each year as a result of medical errors.
- "The U.S. population does not have anywhere near the best health in the world. Of 13 countries in a recent comparison, the United States ranks an average of 12th (second from the bottom for 16 available health indicators."
- The U.S. ranks behind Japan, Sweden, Canada, France, Australia, Spain, Finland, the Netherlands, the United Kingdom, Denmark, and Belgium.
- The United States ranks:
  - —13th (last) for low-birth weight percentages
  - —13th for neonatal mortality and infant mortality overall
  - —11th for postnatal mortality
  - —13th for years of potential life lost (excluding external causes)
  - —11th for life expectancy at 1 year for females, 12th for males
  - —10th for life expectancy at 15 years for females, 12th for males
  - —10th for life expectancy at 40 years for females and 9th for males
  - —7th for life expectancy at 65 years for females and 7th for males
  - —10th for age-adjusted mortality.
- The poor performance of the United States was recently confirmed by the World Health Organization, which used different indicators, and ranked the United States as 15th among 25 industrialized countries
- "Thus, the figures regarding the poor position of the United States in health worldwide are robust and not dependent on the particular measures used."
- Explanations for this poor performance do not implicate the health system, but rather implies it is the result of smoking, drinking, and violence. However, this is not supported by the data.
- The proportion of females who smoke ranges from 14 percent in Japan to 41 percent in Denmark. In the United States, it is 24 percent (fifth best).

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(3)

• "The health care system also may contribute to poor health through its adverse effects." For example:

12,000 deaths/year from unnecessary surgery
7,000 deaths/year from medication errors in hospitals
20,000 deaths/year from other errors in hospitals
80,000 deaths/year from nosocomial infections in hospitals
106,000 deaths/year from non-error, adverse effects of medications
"These total to 225,000 deaths per year from iatrogenic causes."

• "These estimates are for deaths only and do not include adverse effects that are associated with disability or discomfort."

• If other estimates are used, the deaths due to iatrogenic causes would range from 230,000 to 284,000.

• "In any case, 225,000 deaths per year constitutes the third leading cause of death in the United States, after deaths from heart disease and cancer."

• An estimate of adverse effects in outpatient care and including adverse effects other than death concluded that between 4 percent and 18 percent of consecutive patients experience adverse effects in outpatient settings, resulting in 116 million extra physician visits, 77 million extra prescriptions, 17 million emergency department visits, 8 million hospitalizations, 3 million long-term admissions, 199,000 additional deaths, and $77 billion in extra costs.

The author notes that there is a "relationship between iatrogenic effects (including both error and non-error adverse events) and type of care received." Specifically, there is a high availability of medical technology in the United States; i.e., the availability of MRI and CT in the U.S. is second only to Japan. However, Japan, ranks highest on health, whereas the United States ranks among the lowest. Dr. Starfield explains this by noting that the results of such diagnostic procedures often result in the patient being hospitalized, causing a "cascade effect" that leads to an adverse iatrogenic event, while in Japan, such diagnostic procedures result in "the common practice of having family members rather than hospital staff provide the amenities of hospital care."

• "Recognition of the harmful effects of health care interventions, and the likely possibility that they account for a substantial proportion of the excess deaths in the United States compared with other comparably industrialized nations, sheds new light on imperatives for research and health policy."

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(4)

'Doctor-caused' fatalities:
Third Cause of US Deaths

Data released this year in the major publication of organized standard (allopathic) medicine make it clear:

Iatrogenic – that is, "doctor-caused" – disease is the third leading cause of disease in the United States, trailing only cerebrovascular ("heart") disease and cancer.

The *Journal of the American Medical Assn. (JAMA)* made estimates ranging from 235,000 to 284,000 deaths per year due to doctor-related causes. The figures were considered conservative in some circles and, in terms of side effects due to correctly prescribed legal drugs, somewhat lower than those earlier reported by the Institute of Medicine (IOM).

Critics of the report noted that the figures were derived from studies of hospitalized patients and address only deaths rather than disabilities and other side effects from medical errors.

The July 26 (*JAMA*, Vol. 284) account reports 12,000 deaths from "unnecessary" surgeries per year, at least 7,000 medication errors in hospitals, 20,000 other kinds of hospital errors, some 80,000 infections picked up in hospitals, and 106,000 negative effects from drugs allegedly correctly prescribed and administered (earlier estimates in this area have been as high as 140,000).

Noted Joseph M. Marcola DO in *Townsend Letter for Doctors and Patients* (October 2000):

"These statistics prove very clearly that the system is just not working. It is broken and in desperate need of repair."

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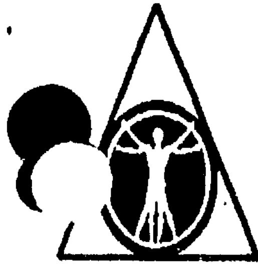

The Free Radical

Feb. 2003

(5)

NEWSLETTER OF THE ARIZONA HOMEOPATHIC AND INTEGRATIVE MEDICAL ASSOCIATION

NEXT AHIMA EDUCATIONAL PROGRAM

Wednesday, February 5, 2003 7:15pm

To be held at COWDEN CENTER
9202 N. 2nd Street, Phoenix

Paula Baker, Bau Biology Architect

Author: Prescription for a Healthy House

will speak on:

"Air, Water, and Electric Quality on Dwellings and the Impact of Green Architecture"

Executive Committee Meeting ...at 6:00pm

PRESIDENT'S MESSAGE

Date line January 23, 2003, Health Sciences Institute e-alert:
The New England Journal of Medicine recently cited a nationwide study of 1,000 patients faced with the prospect of heart surgery, such as balloon angioplasty or bypass operations. The study showed that death due to heart attack was more that 210% HIGHER for patients who chose surgery, than those who refused the surgery.

Since 1977, similar studies have returned results that confirm this more recent study. In the late 90's, for instance, the Los Angeles Times reported on a study demonstrati g that unnecessary heart surgery increased the in-hospital death rate by more thar [illegible]%. And, by some estimates, bypass surgery and angioplasty cause more than 30,[illegible] in-hospital deaths in the U.S. each year. The important distinction here is that these deaths are not caused by heart disease, but by surgery.

The safe and considerably less expensive option is chelation therapy. I.V. chelation can now be given in about ten minutes, using the latest advancements. Oral supplements increase the benefit of the process of removing heavy metals from the body and improving blood flow in the arteries.

With all of the advances in chelation and supplementation and the access to the excellent homeopathic chelation specialists that we have in Arizona, the citizens here have a greater option for healthy hearts and arteries than in most other states, and they need 'o be aware of it and take advantage of it. We are fortunate to be a part of it.
~Kent L. Pomeroy M.D., M.D.(H)

Be My Valentine

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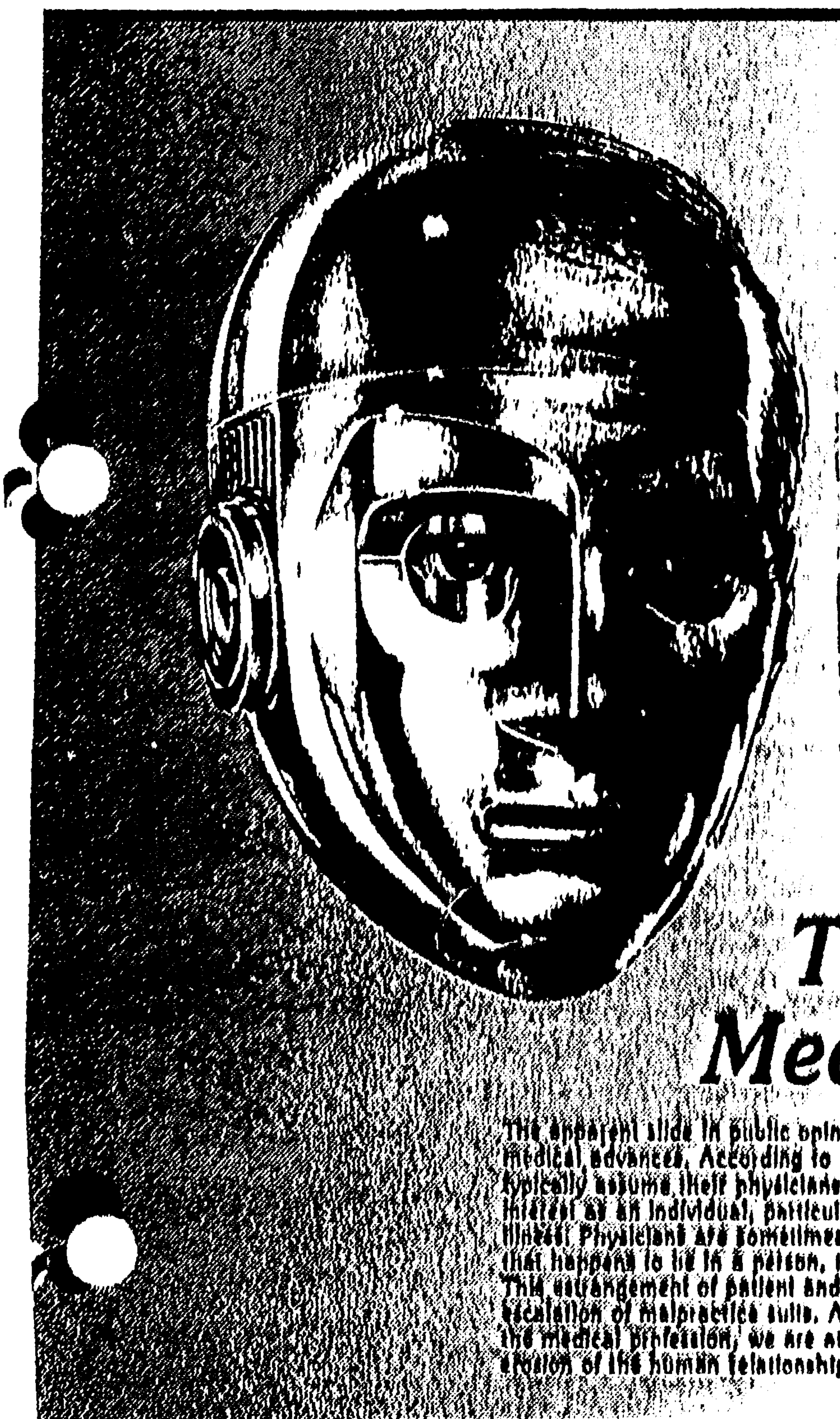
(6)

News Review

University of North Dakota School of Medicine

Vol. 10
No. 2
January, 1985



Teaching Medical Ethics

The apparent slide in public opinion of physicians has coincided with remarkable medical advances. According to a recent New England Journal of Medicine, patients typically assume their physicians are technically competent, but look for warmth and interest as an individual, particularly in the presence of a frightening or debilitating illness. Physicians are sometimes criticized for being more interested in a disease that happens to lie in a person, than in the person who happens to have a disease. This estrangement of patient and physician is responsible, some say, for the jolting escalation of malpractice suits. As a medical school, seeking to prepare people for the medical profession, we are attempting to address the core of these concerns, the erosion of the human relationship.

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Teaching Medical Ethics

"Physicians have a medical education, an M.D. degree, a set of skills, knowledge, prestige, titles. They possess many things by which they mistakenly identify themselves and their profession. Many of the health professions — medicine in-[illegible]uded — confuse the possession of [illegible]ckets of knowledge, a white coat, or a [illegible]nique with being a physician or [illegible]ler."

So writes Edmund D. Pellegrino, M.D., in "To Be a Physician" in the journal, Medical Ethics. "Whatever else it may be, medicine comes fully into existence only in the moment of clinical truth, in the act of making a clinical decision. In this act, the physician chooses a right healing action, one that will restore health or contain established disease or prevent new disease. Among the many things that can be done, the focal point on which all medical activity converges is a choice of those that should be done for this person, at this time, and in this life situation. The right decision is the one that is good for this patient — not patients in general, nor what is good for physicians, for science, or even for society as a whole.

"As soon as we introduce the word 'right' with respect to action and 'good' with respect to an end, we introduce morality — some system of strongly held beliefs against which behavior is to be [illegible]ged as good or bad. Medicine is, [illegible]efore, at the root a moral enterprise [illegible] use values enter into every decision. [illegible] physician's art and science are necessarily shaped by the special human relationship between a vulnerable person seeking to be healed and another professing to heal."

In an effort to introduce medical students to that special human relationship and to the tremendously complex ethical issues which their profession will present, Dean Tom M. Johnson of the UND School of Medicine has been working toward strengthening the teaching of medical ethics.

Spearheading this effort is Dr. Edward Waldron, director of the school's Office of Ethics and Humanities who, two years ago, drew together a small band of people with a professed interest in ethics and humanities to advise the school on how it might best include learning experience of this kind. Committee members are: Art Johnson, chaplain for the St. Luke's Hospital, Fargo; Dr. Ed Olmstead, clinical professor of internal medicine, Grand Forks; Dr. John Martsolf, associate professor of pediatrics, Grand Forks; Dr. David Todd, associate professor of surgery, Fargo; Dr. Tom Akers, professor of physiology, Grand Forks; Dr. Robert Lewis, professor of English, Grand Forks, and Dr. Lynn Lindholm, chairwoman and associate professor of philosophy, Grand Forks.

This Advisory Committee on the Role of Ethics and Humanities first devoted its energies to drafting a proposal which advocates "the development of experiences in ethics and the humanities in the educational structure of UNDSM which will help keep before medical students two central concepts:

"(1) that there are other considerations in the treatment of human beings who are ill than the purely scientific ones, and

"(2) that there is always at the center of a physician's practice a human being who is unique and deserving of respect and attention."

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Students have gained an "early introduction to (ethical) problems and found that there really are no easy answers," said Dr. David Lambeth, associate professor of biochemistry and molecular biology. "It's been a very valuable experience."

"We were pleasantly surprised" at students' enthusiasm for the topic and desire for more, Waldron said, but understood that since these issues bombard the public daily it is little wonder students are very interested.

After this introduction, the first case presented in the freshman Focal Problems class, small group discussion class in the freshman and sophomore year, centers on an ethical issue.

"We used a case in which a couple learns their son has leukemia but they refuse treatment, choosing instead to take him to a faith healer," Waldron said. Other focal problems during the first and second year also present ethical issues, but they are not the primary thrust of the problems.

In addition, Waldron has offered a mini-course, Images of the Surgeon, showing how the surgeon has been portrayed in literature, including sources such as the Atlantic Monthly and the film and TV series, M.A.S.H., and hopes to offer more electives.

For several years, the behavioral science course, lead by Dr. Joy Query and Dr. Sharon Wilsnack, has explored issues surrounding medical sociology and medical ethics.

"We hoped to lay the groundwork for the first two years (of medical school) and work with them in the second two years when they begin to experience patient care firsthand," Waldron said. "The problem is getting the third and fourth year students together — they're spread out in four locations."

On the drawing board for clinical science years, three and four, is introduction of ethical issues discussion in grand rounds, beginning, it is hoped, with pediatrics. If this plan works well, it will be "used as a model for what we can do in other areas," Waldron said.

Another problem that poses the most serious obstacle is attempting to add material to a curriculum that is already overcrowded. According to Dr. David Lambeth, head of the school's curriculum committee and associate professor of biochemistry, "No one would disagree on the importance of teaching (ethics and humanities); we have taken a position of strengthening what we now have and looking at opportunities to teach it that are being missed."

"There is no conflict between the scientific method and the need in the medical curriculum for subjects that deal with human values," states Norman Cousins on the value of the humanities in medical education in the introduction to The Physician in Literature. "Values constitute a moral system that transcends change. When values are strong enough and good enough, changes in science can be fitted into the lives of people, making it unnecessary to fit people into change.

"The way people are dealt with as patients can be as important as all the other treatment they receive in an attempt to ease or cure their ills. That is, the effectiveness of the doctor as scientist is tied to his or her qualifications as artist and philosopher — to those intangible credentials that have to do with character and personal dimensions."

Strengthening the teaching of ethics and humanities in medical school is "an on-going process as I see it," Lambeth said. It will be accomplished by working with various course directors," building it in where appropriate.

The curriculum committee has stopped short, however, of recommending ethics and humanities *requirements* for medical school admission, prefering to stress advising students of the need for a well-rounded education.

"Historically, medical schools' admission committees have backed off on what's expected (in the sciences) — we've backed off a little bit on sciences — putting more emphasis on humanities."

Medical schools are constantly pressured to demand more or less of t' subject or that, depending on the special interest group. Internally, they feel the same pressure, he said, "we never do as well in any one area as people in that area believe we should; biochemists never believe students graduate with enough biochemistry, anatomists enough anatomy, etc. . . .

"We have 30 hours per week of class and lab experiences — and they're filled. A special required course would mean cutting back elsewhere."

Dean Tom Johnson agreed: "There is so much material to be learned — and it's not improving one iota. What do you do about ethics and humanities?

"The future conflict between quality of care and cost of care will be a fundamental issue. The rationing of medical care will be ethically based. Orders of 'do not resuscitate' will present tough questions.

"We have to prepare our students for 40 to 50 years of practice in an increasingly complex field. They need to be versed in communication — spoken and written; computers; humanities — to have a certain understanding of the human condition, and an introduction to ethics.

"I don't see this as in any way devaluing the sciences we require."

Cousins: "We are seeing a new breed of scientific humanist and humanistic scientist. The separation of the two intellectual worlds is giving way to a realization that they are both dependent on the conditions of creativity and on the need to accept responsibility for their work. The trend has been moving away from scientists who make public proclamations about the morally antiseptic nature of their calling and the real division is . . . between those who attach primary importance to human life and those who view their own discipline as sovereign."

"What do you do about ethics and humanities?" Johnson asks. "The question is not if they're important — that's not debated. But when and how we can best present it to students at the points they need to learn it."

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"To be a physician is freely to commit oneself to the moral center of the relationship with the patient and to do so with one's whole person. . . that is the only condition for freedom, as Bergson so rightly observed," Pellegrino writes. "This is neither too harsh nor too simplistic a judgment. The malaise of medicine . . . the moral desuetude so many see in us and the bewilderment of our students about what we are is rooted in our failure to sense the dimension of being a physician.

"Without this dimension, even the idea of service can become degraded into mere performance of a function. Many of us function, but few serve. To transform functions into service, we need what Marcel called attachment: 'dedication to the intrinsic quality of what is done, its adaptation to the needs of the person served and personal accountability for its quality.'

"We cannot distinguish having from being without the capacity for critical self-examination. This is what the humanities — philosophy, history, literature at their best — have always taught the educated man. These studies are, therefore, tools of that intellectual and moral honesty which gives the lie to self-assurance and forces a constant reexamination of motives and values. There is no more effective antidote to the overweening pride that can so easily beset the physician."

The rationale for including ethics and humanities experience within the medical school curriculum, according to the com[mitte]e's proposal, is:

•That medical education, especially in [the firs]t two years, unfortunately removes [from th]e student's concern the fact that [the] goal toward which he or she is working involves interaction with human beings who have certain expectations (and rights) concerning that interaction

•That the dehumanization of the patient in the course of a medical student's education, while perhaps necessary, does little to prepare the student for working with patients as people later

•That pressures inherent in medical education do not guarantee a sense of respect for the patient as a human being with his or her own set of values and beliefs and a right to be involved in decisions concerning the treatment of his or her illness, and

•That decision-making which involves ethical issues requires formal education.

What we propose is designed to enhance the art involved in the art and science of being a physician, the proposal states.

"The question before the committee wa[s h]ow material on ethics and [humanit]ies could be introduced into the [curriculu]m and other experiences at all [levels," W]aldron said.

[Wh]at they came up with was a set of recommendations concerning premedical requirements, formal discussions and

means of infusing ethics and humanities into the four years of undergraduate medical education and residency training.

During Phase I, the first two weeks of the freshman year, students in small groups receive their first exposure to cases presenting an ethical dilemma. They face situations they may not have been aware existed:

•Babies born with severe physical deficiencies — should physicians always do everything possible to sustain life? Do parents have any rights to decide what is or is not done? Who decides on care? Students discuss the controversial Baby Jane Doe case, in which Bloomington, IN, parents, won a court suit to deny their newborn food.

And if the law requires rescue of all handicapped infants, will parents be required to support and care for them? Or should society be obliged to provide institutional care?

•A physician goes to court to force a pregnant woman by court order to stop taking drugs that will affect her 7-month fetus and to have urinalysis to insure she is complying with the order.

Should government health agencies set prenatal health standards against harmful habits like drinking, smoking, drug use? Should physicians then be required to report to authorities pregnant patients who break the rules in the way they must now report cases of VD?

A few decades ago, mental patients and retarded women were routinely given abortions and sterilized by doctors on court order because they were deemed unfit parents likely to produce defective offspring, the lesson reads. Later, this practice was exposed as a scandalous violation of human dignity and of civil rights, now enforced sterilization is severely regulated or barred altogether. Or, does this woman's case show that in some cases, parenthood must be denied or restricted?

•A 68-year-old man who has suffered severe injury in a car accident refuses surgery for internal hemorrhage saying he wants to be "left alone to die." Physicians learn he was diagnosed three weeks earlier as having carcinoma of the tongue, for which he refused surgery and asked his own physician not to tell his wife that he has a fatal disease.

The hospital physicians believe that he will die without surgery for the hemorrhage, and they call a psychiatric resident to evaluate the patient. The resident interviews him and finds him coherent, rational and alert. The patient describes himself as a man who values independence. He feels that he has had a good professional life as an engineer and a good personal life with his wife and two children. He expresses *some sadness at his situation, but says, "I have had a good full life and now it's over."*

The resident suggests, and the patient does not deny, that the auto accident was a deliberate suicide attempt. What should the resident recommend? That the patient's refusing immediate surgery be accepted as the act of a rational person? That the refusal not be honored, and a court order sought on the grounds that a presumed suicide attempt is per se evidence of mental illness?

Spirited disagreement and lively exchange accentuated discussion of these cases. Evaluation by students after Phase I revealed that they enjoyed bending their thoughts in other than scientific patterns and requested more opportunities for these kinds of experiences.

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(10)

New York is going after CAM meds

USA — New York State may have one of the US' most liberal "alternative/complementary medicine" (CAM) laws on the books, but activities of the state's stepped-up harassment of CAM physicians has left health-freedoms proponents wondering:

In recent years, such front-line integrative physicians as Serafina Corsello MD, not to mention innovators such as Jennifer Daniels (MD) — who has successfully treated diabetics with diet and exercise — and Charles Gant MD — who has reportedly had favorable outcomes treating ADD/ADHD without prescription drugs — have run afoul of the state's Office of Professional Medical Conduct (OPMC) and are or have been under OPMC investigation.

Even orthodox doctors who seem to operate just outside strict guidelines have felt the OPMC's wrath (as in the case of Joseph Burrascano MD, discussed by Healthwave's Marcus Cohen in the August/September *Townsend Letter for Doctors and Patients*).

Arnold Gore, Consumers Health Freedom Coalition (CMC) and a long-term OPMC watcher noted (*in TLDP, July*):

"In 1994, FAIM (Foundation for Advancement in Innovative Medicine) . . . was instrumental in passing the Alternative Medical Practice Act that we thought would protect alternative doctors from losing their license(s) just because they treat disease with non-standard therapies.

"In the intervening years, the climate has officially tolerated, if not embraced, alternative medicine. Some might even say a suffocating embrace.

"Almost every major hospital has a program or division to show commitment to the use of alternative medical treatments.

"These programs are often called complementary or integrative medicine, in which ideally the best of alternative medicine can be combined with the best of conventional medicine to serve the greater interests of the patient.

"Unfortunately, much of the effort is a public relations stunt to protect the medical delivery system and its economic interests from the threat of competition from alternative medical doctors."

* Complementary and Alternative Medicine.

Florida health-freedoms bill wins by landslide

USA — Health-freedoms legislation which swept to victory in Florida almost in a breeze this spring brought to 14 the number of states which in one form or another have enshrined the right of doctors and patients to opt for "alternative" medicine.

The sweeping Sunshine State legislation (Rep. Connie Mack's H 1077 and Senator Durell Peaden's S 1324, introduced March 9) was also another solid setback for the small but noisy band of attention-getting "quackbusters" who rail against all departures from standard or allopathic medicine.

The Senate bill passed 35-1 and the House legislation won unanimously.

The Citizens For Health Freedom coalition led the Florida effort.

The bills authorize provision of and access to complementary or alternative healthcare treatments by all healthcare licensees, require patients be provided with information on the same, and revise the Florida Patient's Bill of Rights and Responsibilities to include the right to access any mode of treatment the patient or the patient's healthcare practitioner believes is in the patient's best interest (*see companion story*).

In recent years, the following 12 states, now joined by Florida, have passed similar freedom-of-choice legislation: Alaska, Colorado, Georgia, Massachusetts, Minnesota, New York, North Carolina, Ohio, Oklahoma, Oregon, Texas and Washington.

Another — Nevada — already has regulations to protect patient access to alternative therapies.

In the heyday of the laetrile revolt 24 states eventually passed legislation providing access to this specific "unauthorized" anti-cancer treatment, although a few have rescinded the legislation.

Patient access to EDTA chelation therapy, available by court decision in some states (as in Florida and California), is specifically protected in South Dakota and Louisiana. Naturopathy is currently licensed in Alaska, Arizona, Connecticut, Hawaii, Maine, Montana, New Hampshire, Oregon, Utah, Vermont and Washington.

Between the states with broad access to alternative medicine or to specific forms (EDTA and laetrile), and aside from the virtual total legality of acupuncture/acupressure, "oriental medicine" and homeopathy in a majority of states, it is clear that well over half the states of the USA protect alternative therapy at one or more levels and have done so since the outbreak of the laetrile legislative revolt in Alaska in 1975.

'Legislative intent'

USA — The core and marrow of the recently passed Florida health-freedoms legislation is the creation of a new section — 456.41 — to the Florida Statutes, entitled "complementary or alternative healthcare treatments."

Its "legislative intent" reads:

"It is the intent of the Legislature that citizens be able to make informed choices for any type of healthcare they deem to be an effective option for treating human disease, pain, injury, deformity, or other physical or mental condition.

"It is the intent of the Legislature that citizens be able to choose from all healthcare options, including the prevailing or conventional treatment methods as well as other treatments designed to complement or substitute for the prevailing or conventional treatment methods.

"It is the intent of the Legislature that healthcare practitioners be able to offer complementary or alternative healthcare treatments with the same requirements, provisions, and liabilities as those associated with the prevailing or conventional treatment methods."

Moreover, Section 381.026, Florida Statutes, is amended to include as (d) 3:

"A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her healthcare practitioner, in the best interests of the patient, including complementary or alternative healthcare treatments, in accordance with the provisions of FS.456.41."

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Comments Supporting House Bill 1376

My name is Richard Hammond and I am taking EDTA Chelation as an alternative treatment for heart and circulation problems. The availability within the state of many alternative therapy's and treatments is limited largely due to the combined efforts of the State Medical Association and the State Board of Medical Examiners.

This, or similar, legislation has been before the legislature several times. This is Medical Freedom Legislation. This legislation addresses both my freedom to select a course of treatment from the various treatments available, and my physician's right to offer that treatment. Presently, nine states have passed some form of Medical Freedom Statute. They are: Alaska, Colorado, Georgia, New York, North Carolina, Oregon, Oklahoma, South Dakota, and Washington. This legislation is necessary because neither the Medical Association, nor the Medical Board respect the citizen's right to select any type of alternative treatment.

I have a right to select a form of alternative treatment for myself. Each of you here has the same right to choose a treatment for yourself. Just as I do not have the right to choose a treatment for you, you do not have the right to choose a treatment for me. The medical establishment does not have the right to either choose a treatment for me, or to limit my available choices. The days of "doctor's orders" are past. In today's world, a medical doctor is a consultant who makes recommendations to the patient. The patient is free to accept or reject those recommendations. This principle must be set forth in the statute because the medical establishment does not fully accept this change. When there is no misrepresentation or harm to the patient, the State Board of Medical Examiners should have no authority to regulate or interfere in the practice.

During the summer after a similar proposal was defeated in the 1997 legislative session, I went to the legislative archives

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and listened to the audio tape recording of the committee deliberations on this subject after the public hearing was closed. I was distressed to see the discussion centered around whether each committee member thought one alternative treatment was a an acceptable treatment. Many of the then committee members missed the central issue in this matter. What was not understood in the discussion, is that each committee member has the right to make that decision for themselves, and themselves only. The key to this is my right to make that decision for myself. And any citizen's right to make that decision for themselves.

Before I chose to take EDTA chelation treatments, I did research at the public library. My research included investigating possible harms resulting from the treatment. For that research, I went to the State Law Library here and searched for medical malpractice cases involving chelation as a treatment. This will be a true measure of the dangers, if they exist. There are no malpractice cases resulting from patient harm. The only malpractice case listed involving chelation therapy was a situation, in another state, in which a patient sued his physician following an open heart operation for not informing the patient that chelation therapy was available as a non invasive alternative.

Testimony in previous legislative sessions by the medical establishment in opposition to medical freedom legislation has been misleading at best. They will claim great dangers and provide a list of side effects that simply is misleading. Any medication can exhibit dangerous side effects when taken in an improper dose. We can be assured that if there were any cases of patient injury in the last 20 years, the Board of Medical Examiners would make as large of an example as possible of the incident. The bottom line is that the objections raised by the medical establishment are a pretext and the real underlying concern is purely economic.

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One of the commonly asked questions is why do we need this bill if EDTA chelation is now available in the state. The bill is necessary because the medical establishment, using the State Board of Medical Examiners, has sent a clear message that any doctor who attempts to stray from the established mainstream of "acceptable" treatments, will pay the price. The medical board will use the it's power and authority to destroy the doctors practice or as a minimum make that doctor's life miserable.

One of the disturbing aspects relating to consideration of this legislation is the relationship which we observe between the State Medical Association and the State Board of Medical Examiners. These are two separate organizations with two completely separate functions. The Medical Association is the labor union which represents the private and business interests of the medical doctors. The State Board of Medical Examiners is a State Agency which is supposed to represent the interests of the citizens of the state. There should properly be a wall of separation between the private association and the State Board charged with regulating the members of that association. When attending these hearings I frequently observe the lobbyist for the Medical Association and the Attorney for the State Medical Board sitting together and testifying in unison with the same position on legislation. The Medical Board exists to protect the citizens of the state. The close relationship is, at best, a serious conflict of interest which does not serve the citizens of the state. I question the credibility of the State medical board.

When the state delegates power and authority to any political subdivision or board or commission, there is a responsibility to review or monitor the use of that power and authority and to adjust the laws or regulations when necessary. To simply grant powers and authority and close the book, and never review the results of the grant of authority, is to do a disservice to the citizens of the state. This adjustment or clarification in HB 1376 is necessary.

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Donna Hallraith 10/3/03
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The trend across the country is to pass medical freedom legislation to protect both the citizens' right to select treatment alternatives and a practitioner's right to offer alternative treatment. I request that the State of North Dakota step up and be in the forefront of that trend and not be one of the last states to accept responsible and necessary change.

Richard Hammond

701-223-5126

EDTA ethylene diamine tetra-acetic acid

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Feb 10, 2003 House Bill 1376

Freedom of **medicine** is an equal to freedom of **religion**. This is my body and I do not want an institution or governmental agency telling me what kind of medicine is most beneficial to my personal health.

I trusted my health and well being to orthodox medical treatment, and the treatment I received left me in worse shape than I was before the treatment. It only took one orthodox Doctor to screw up my life and now it is hard to find an orthodox Doctor to treat me, I can only assume that this because no Doctor wants to be blamed for damage some other Doctor has done to my body. When the orthodox medical community deserted me, I sought alternative medicine as a way to find relief from my suffering.

Dr. Brian Briggs of Minot, ND an alternative medicine provider, who is registered by the appropriate government authority gave me more relief from my pain an suffering with one office visit than I received after thousands of dollar worth of tests and treatment from an orthodox Doctor.

I do not believe that I can express in words the relief from pain and suffering and also peace of mind my husband and I have received by choosing alternative medicine as the most beneficial to our personal health.

I ask that no alternative medical provider, that is duly registered and licensed by the appropriate government authority, be found unqualified nor denied the right to pursue his or her professional practice. I also ask that you leave the right to choose his or her personal health care to each and every citizen. Each and every American citizen has freedom of religion now let us have freedom of medicine.

therefore pass bill 1376

Submitted by:
Ruth Schell

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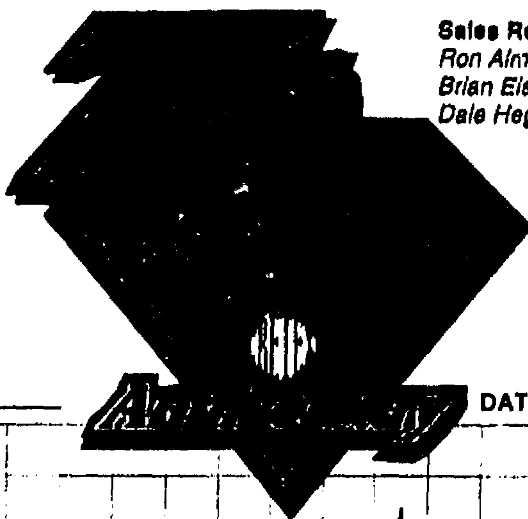

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(1)

Testimony before the House Human Services Committee
Feb 10, 2003 House Bill 1376

Chairman Price and members of the House Human Services Committee; I am pleased to be here this morning.

Have any of you been diagnosed with cancer?

In June of 2000, I heard the words. you have CANCER.

An appointment at the Mayo Clinic in Rochester, Minnesota was made.

I had a mastectomy July 8, 2000 and was told To go home, contact my doctor + do follow up chemotherapy, radiation and tomoxifen treatment-

IMAGE

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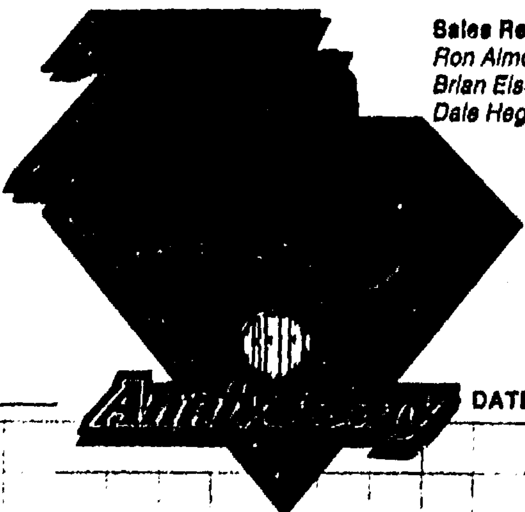

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I did not tell my doctor at Mayo that my doctor back home was an alternative doctor, and that thru my own choice, I would be doing alternative therapy and NOT the therapy that the Mayo doctor had recommended -- Chemo, radiation + tamoxifin.

This was my choice, after hearing the many horror stories of the side effects one encounters by doing the traditional treatments.

It has been 2 years and 7 months since I've had my cancer surgery. I've been given a clean bill of health and feel great.

I am so very thankful that there was and is a physician available near me who offers alternative therapy and nutritional counciling.

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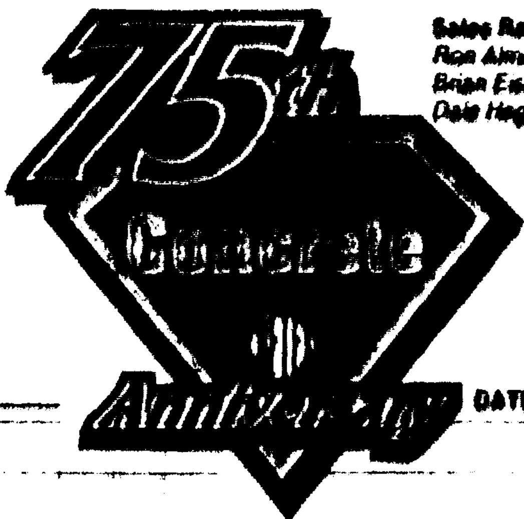

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(3)

It should be my choice, my right and my freedom To choose the type of therapy I feel is best for me, without going To Mexico.

If House Bill 1376 is passed, it will encourage other physicians to feel more secure in offering alternative therapy To patients.

I urge each of you To vote DO Pass on House Bill 1376.

I thank you for taking time To listen to me this morning and would be happy To answer any questions you may have.

Clayanna Almquist
2700 74th ST. NW
Minot, ND 58703
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[signature] 10/3/03
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HOUSE BILL NO. 1376

February 10, 2002

Madame Chairwoman, Committee Members, and interested fellow citizens:

I am Mrs. Constance R. Briggs, office manager for Dr. Briggs of Minot, ND.
I am here to support H. B. 1376 to amend and re-enact subsection 21 of section 43-17-31 of the North Dakota Century Code.

The predicament the physician of complementary and alternative medicine parallels the chiropractor and osteopathic physicians prior to 1988.

These professional men were called quacks, charletons, hucksters, unscientific, killers, rabid dogs, and cultists.

There was a design to stop all chiropractors just as the Federation of State Medical Board's decision to stop all alternative/complementary medicine in the USA last year.

The same tactics to stop Blue Shield and Medicare payments as well as keep the alternative/complementary physician out of the hospitals are a blueprint of the years of chiropractic oppression.

It took eleven years in the courtroom against the AMA for their monopolistic tactics to win their battle. Slowly things are changing. Reluctantly the BS/Medicare have been forced to reimburse chiropractors for their services. In America people are supposed to be given freedom of choice. But it is always a struggle against greed and power.

I had great respect for the honorable profession of medical physicians until I realized they would amputate limbs before exhausting all procedures to avoid such trauma to a person. We have seen gangrenous, ulcerated limbs return to normal by the use of chelation in addition to returning people to the work force after having blocked arteries, et al. Simply washing the food color (which is made from coal tar) from medications make them effective and harmless unless, of course, the patient is sensitive to the compound itself, people who have been confined to their home because of allergy-sensitivities after years of struggling return to functioning in society again – to mention but a few.

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Some of the orthodox physicians have told Dr. Briggs they would like to do what he is doing, but they are afraid.

The information about the chiropractors' plight was obtained from a booklet called FINALLY AFTER 11 YEARS THE FEDERAL COURT IN CHICAGO, ILLINOIS FOUND THE AMERICAN MEDICAL ASSOCIATION GUILTY!!! OF CONSPIRING TO DESTROY THE PROFESSION OF CHIROPRACTIC.

The parallelism of this report and the plight of the alternative/complementary physician is impressive. Further training of the alternative/complementary physician is received at their scientific twice-a-year meetings. Several groups exist and they continue to grow in numbers. All alternative/complementary physicians have had the basic orthodox medical training.

Doesn't it seem unreasonable to categorize alternative/complementary/ eclectic medicine as "inappropriate care?

Respectfully submitted,

Constance R. Briggs

Constance R. Briggs

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Date

North Dakota State
Board of Medical Examiners

ROLF P. SLETTEN
Executive Secretary and Treasurer

LYNETTE McDONALD
Administrative Assistant

TO: HOUSE HUMAN SERVICES COMMITTEE

FROM: ROLF P. SLETTEN, EXECUTIVE SECRETARY & TREASURER

RE: HB 1376

DATE: FEBRUARY 10, 2003

This bill was presented in substantially the same form in 1991, 1993 and 1995 and twice in 1997. This is the sixth time this bill has come before the Legislature.

1. This bill is intended to accommodate the unusual medical practices of <u>one</u> man, Brian E. Briggs, M.D., of Minot.
2. Dr. Briggs' license to practice in Minnesota has been revoked.
3. Dr. Briggs' license to practice in Illinois has been revoked.
4. Dr. Briggs' license to practice in Virginia has been revoked.
5. Dr. Briggs' license to practice in California has been revoked.
6. Dr. Briggs' has been suspended by the U.S. Dept. of Health and Human Services.
7. On July 23, 1984, Dr. Briggs' license to practice in North Dakota was placed on probation.
8. On March 1, 1990, Dr. Briggs' license to practice in North Dakota was suspended for one year.

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9. Dr. Briggs practices out of his house in Minot - he has lost his privileges to practice at the hospitals.
10. The really frightening thing about this bill is that it would effectively force the Board of Medical Examiners to stand idly by waiting for someone to get hurt while a few unorthodox practitioners conduct medical experiments on human beings in North Dakota.
11. The terms "complimentary" and "alternative therapies" are undefined and appear to be very thin euphemisms for unorthodox medical experimentation.
12. The USFDA spends huge amounts of money and effort to insure that people are not used as guinea pigs for unproven, untested, or just plain bizarre ideas. This bill would effectively remove many of those safeguards in North Dakota.
13. The idea that the Board would have to stand by waiting for someone to get hurt is really dangerous. This language provides tremendous potential for serious harm to be inflicted on innocent and unsuspecting folks. In addition, the Board would have no power to stop a dishonest practitioner from "ripping people off" with worthless "alternative therapies".

For all of these reasons, the North Dakota Board of Medical Examiners strongly urges the Committee to reject HB 1376.

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