THE WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

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RE: PLANNING MEETING : Volume II
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ORIGINAL

Hubert H. Humphrey Building
Room 800
20 Independence Avenue, S.W.
Washington, DC 20201

Friday,
July 14, 2000

The above-entitled matter came on for hearing, pursuant to adjournment, commencing at 8:40 a.m.

COMMISSION MEMBERS PRESENT:

JAMES GORDON, M.D., CHAIR
Director, The Center for
Mind-Body Medicine
Washington, DC

GEORGE M. BERNIER, JR., M.D.
V.P. for Education
University of Texas Medical Branch
Galveston, TX

THOMAS CHAPPELL
Co-founder and President
Tom's of Maine
Kennebunk, ME

EFFIE CHOW
President and Founder of
East-West Academy for the Healing Arts
San Francisco, CA

GEORGE T. DEVRIES, III
Chair, President and CEO
American Specialty Health Plans
San Diego, CA

APPEARANCES: (continued)

WILLIAM R. FAIR, M.D.

Director, Prostate Diagnostic Center
Memorial Sloan-Kettering Cancer Center
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MAURY SILVERMAN

EXECUTIVE STAFF:

STEPHEN C. GROFT, Pharm.D., Exec. Director
MICHELE M. CHANG, M.P.M., Exec. Secretary

A G E N D A

P R O C E E D I N G S

8:40 a.m.

DR. GORDON: The meeting is going to begin.

Again, let's just sit quietly and gather ourselves together here.

(Whereupon, a Period of Silence was observed.)

DR. GORDON: I have a question. Is that a nice amount of time for an opening meditation/relaxation? Would you like do to more or less? Is that okay?

MR. CHAPPELL: Very nice.

DR. GORDON: Great. Okay.

We have three major areas that we're going to address today and then we're going to talk some about the logistics of how we're going to proceed. And then from 1:00 to 2:00 we have public comment.

I want to do two things before we move into those areas. I know that because of the suddenness, if you will, of calling this meeting, that some of you have to leave early. So I'd like to get a handle on those who cannot stay. And we may finish early anyway. But I do want to get a handle on who can't stay until 5:00 today. Cannot. Okay.

(Pause.)

Okay. So, knowing that, let's see what we can do. And we moved very nicely through yesterday's discussion. I hope we'll be able to keep that up.

And remember, even though we're covering and addressing many different topics, we're going to pull it all together and then get it back to you and then get some much more specific focus on how we're going to proceed.

The other thing that we need to do, and maybe we should do that at the end of the morning, Michele, is make sure everybody fills out those sheets about saying which of the groups or which of the areas that they're most particularly interested in.

MS. CHANG: Don't leave today without giving me the little form that's in your folder about your self-selective committees -- I mean groups.

DR. GORDON: So any issues left from yesterday that anyone wants to address before we move on to the next topic on the agenda?

Effie?

Please turn on your mike. Okay?

MS. CHOW: Good morning, everybody.

I just want to mention that we talk about research --

DR. GORDON: Effie, you've got to speak into

the mike.

MS. CHOW: We talk about research and I wonder if we could just place a little bit more value on the testimonies. Being that we're lacking --

DR. GORDON: I'm sorry. I still can't hear you.

MS. CHOW: -- perhaps lacking in hard research for the different modalities for CAM, that more -- perhaps we could listen to more of the testimonies. In other words, the outcomes of the practices. Because I think we pooh-pooh a lot at testimonies and sort of say, oh, well, that's just the person saying how they feel and there's no candid research protocol and so forth. And perhaps that's one recommendation perhaps. How we can take the testimonies of people and make it perhaps a little bit more applicable to research. That's all.

DR. GORDON: So what the researchers would call qualitative research as well as quantitative research?

MS. CHOW: Yes.

DR. GORDON: Okay. Great.

Any other comments or issues left from yesterday?

(No response.)

* Okay. Great. Then let's move on to Number 2, which -- Steve, you word it as Guidance for Appropriate Access to and Delivery of Complementary and Alternative Medicine. And this -- it sounds small, but this is really huge. This is what issues do we need to address to understand how both the practices and the world view of CAM can be integrated into health care for everybody.

So it's a big topic and we can start anywhere anyone would like with this topic.

You're stunned?

MR. GROFT: Let me just go over a few things about the microphones. When you want to speak, just press the button on the right. And when you're finished, turn it off. If there are six microphones that are on at one time we'll get a ding-dong and everything will just shut off.

So before you speak, just press the button and the red light will come on in front of you and the orange light on the microphone. Okay?

DR. GORDON: Please, George.

MR. DEVRIES: So, Dr. Gordon, when you're talking about access, access to and delivery of complementary and alternative medicine, maybe you can help us, give us some more definition.

Are we talking coverage under insured benefit programs; coverages by pairs; recommendations in terms of licensure, scope of practice; how members will access these services; are they under the indirect/direct supervision of a medical physician or are they not.

Just trying to understand what you're looking for there.

DR. GORDON: The answer is yes. That's part of it. Or, looked at another way, if I'm going to my primary care doctor, if I'm looking around my community, if I'm going to a community mental health center, if I'm going to a hospital, what should I expect. What does CAM, the techniques, the approach, the world view that we discussed yesterday, how can we as a Commission -- what do we need to know to make recommendations to say to Congress we feel that Medicare patients should have -- and Medicaid patients -- should have access to this.

We feel that part of every patient's care should include X, Y or Z. We feel that insurance coverage should include. We feel that such-and-such practitioners should be part of this setting, that setting or the other setting.

It's a huge area. And what we're trying to

do is to get some -- and we know that they're going to be many different aspects of it, and I would anticipate a number of different panels addressing -- one might address access; one might address insurance coverage; one might address staffing patterns; another might address what the government should do immediately in terms of Medicare or Medicaid.

So it's very broad and maybe that's part of the issue.

Dean and then Tom.

DR. ORNISH: I think a primary determinant of access is reimbursement. And one of the fears that a lot of insurance companies and Medicare, for example, have is the issue of fraud and abuse. How do you credential; how do you certify. If Medicare decides to cover an alternative treatment, they're concerned that everybody will just say, oh, yes, I'm a practitioner of that particular treatment. How do we come up with ways of reassuring them that those kinds of abuses are less likely to occur. And often that involves certification or some kind of standardization that often isn't the case, particularly in many alternative approaches.

DR. GORDON: I'm sorry. Offering them what, Dean?

DR. ORNISH: Some kind of standardization,

credentialing, certification. Some way of protecting their legitimate concern about fraud and abuse. And often in the area of complementary and alternative medicine, as you know, there's a dearth of that.

And so, because of that, there's more of a perception and even an reality of being vulnerable to fraud and abuse for people to just claim they're an alternative practitioner and therefore to qualify for reimbursement when that person may not necessarily be qualified.

I think those are issues we may need to address.

DR. GORDON: Okay. I'm going to try to bring out and push a little on all of these issues.

For standardization, who would you want to hear from? What kinds of people or people in what situations would be important to hear? What kinds of information would you like?

DR. ORNISH: I think the kinds of information would be from -- it would be helpful to talk to, first, to other groups that offer standardization, whether it's the NCQA or whether it's the hospital certifications or boards of medicine of one sort or another. Because we're not the first to address this issue of standardization, certification and

credentialing.

There are some groups that are attempting to do that in the alternative or complementary medicine world, as you know. It would be helpful to hear from them.

Many insurance companies, for example, have networks of providers that they certify. Oxford, for example. Some of the Blue Cross Blue Shields. High Mark and others. It would be interesting to know what their experiences have been, what kind of obstacles they've dealt with, what they found to be useful. Because if we're really talking about appropriate access, it's impossible to not also deal with these issues of credentialing and certification, because ultimately those are what are going to be major issues for anybody, any third party payor that's reimbursing complementary and alternative medicine.

And I think a primary determinant of access is reimbursement because in the final analysis, we tend to do what we get paid to do and we even get trained to do what we get paid to do.

DR. GORDON: Great. Thank you very much. That's very helpful.

Tom and then George.

MR. CHAPPELL: As I respond to this question,

I think about the products more than I do the services. And it's appropriate to think about products as well here.

DR. GORDON: Absolutely.

MR. CHAPPELL: And at the present time, the complementary and alternative medicines are expected to fit within the guidelines of either a food, a drug or a supplement, a DSHEA type claim. And they are a very particular vocabulary that must be used if you are fitting yourself into a DSHEA category and there's a language that is otherwise relegated to an over-the-counter drug section.

So, there is no real domain that belongs to complementary and alternative medicines. There is no department for complementary and alternative medicines.

DR. GORDON: Meaning at the FDA?

MR. CHAPPELL: Yes. We are an aberration and we are fit into either the FDA or the FTC at the present time when it comes to products.

That means that makers of products are limited as to what they can say when they decide what claim they're going to make. It means that people who are marketing the products in retail stores are very much disallowed to use certain language.

So there's a whole constraining force

throughout the regulatory field here. Instead, I think given the status and legitimacy that the marketplace is claiming to these products and services today, we need a regulatory and a domain that houses the standards, the language or the claims.

DR. GORDON: And who would you suggest that we -- I keep repeating this question. Who would you suggest that we hear from to help make a recommendation?

MR. CHAPPELL: Well, I think it would be helpful to hear from the FDA, from the FTC so they can tell us the struggles they're having with trying to live up to their charter for the public in addressing this emerging field. That's one.

I think we also ought to hear from those that are marketing products either as manufacturers or as retailers, people on websites. And the best example I can give you is that a lot of new products are coming out that are herbally based and qualify in the DSHEA area, not the OTC area. And after the consumer has read the label, which is loaded with regulatory requirements, their one question is what is this for. But you're not allowed to say what it's for.

So the consumer really loses unless the consumer is doing independent research, third party

research to self educate in this whole field.

The providers are very much limited as to what they can say or promise in the absence of clinicals.

So I think we need a body or at least we need a food, drug and CAM department.

DR. GORDON: Okay. Great. Thank you.

George?

MR. DEVRIES: Really the issue of access and delivery, I've written down a few thoughts and I would separate it into probably four areas.

First of all, I'd start with licensure. And I think we need to really, as a group and as a Commission, I would suggest we make recommendations that individual states would enact legislation for specific minimum levels of licensure for CAM providers.

And just to run through some of our own experience, because we operate networks of CAM providers in all 50 states, and we've run into significant issues. Everything from credentialing and how you select providers and who's qualified and licensed to provide those services in particular states.

I would just note acupuncture as a good

example of really the diversity of licensures that's available or not available across the country. You have probably over 20 states where they're licensed. Like, for example, states like California and other states where there's individual licensing boards in the states and there's an ability for an acupuncturist to become licensed. And then as you go into other states you begin to find that they may not allow licensure. They're more looking to certify the acupuncturist. They may require those acupuncturists to operate under the direct supervisor or the indirect supervision of a medical physician. And then you run into states where there's no statute for either certification or licensure.

And then really we as an organization are looking towards medical physicians. And in our own credentialing standards, we basically are looking for medical physicians who've taken additional training on acupuncture.

And so really as you begin to step down almost -- and I don't mean step down, but I mean as you move through this process, what really happens is the access to acupuncture services begins to diminish. And we find that the more restrictive the licensure process is the fewer providers there are available that

practice acupuncture.

A good example is the state of Ohio, which doesn't have a licensure process. And as we went through the medical acupuncture society and we were looking for medical physicians who took additional training in acupuncture, we only found probably -- and we had other sources -- but two to three dozen medical physicians in the entire state.

As we looked in the Cleveland service area in particular, we only found about half dozen. And of those, a couple of them were anesthesiologists who were simply using acupuncture for their own -- for helping patients coming out of surgery with their nausea related to being under anesthesia.

So I think one recommendation I would make is that we specifically look at licensure. And those issues exist for massage therapy also.

Massage therapy in some states, there's licensure. In other states, like even California, there's no licensure for massage therapists. And in fact, it's basically handled through city or county ordinance. So it's the local city or county government that's making rules and requirements for massage therapists. And really that, I believe, should be at a state level with licensure.

Naturopaths face significant challenges.

DR. GORDON: George, who would you like to hear on these subjects? Who has major contributions to make?

MR. DEVRIES: Well, I think there's a particular acupuncturist. She's an acupuncturist and a lawyer, a lady by the name of Barbara Mitchell out of the Seattle area. And she has significant understanding and tracks the licensure in all 50 states. So she would be a valuable person to hear.

I think there are other individuals who, like her in other professions, specifically track licensure issues. And I think those people would be helpful to have.

DR. GORDON: Are there people at a state or national level or organizations of a state or national level that have looked at this question or that are grappling with this question in ways that are interesting?

MR. DEVRIES: Absolutely. And I think it's just a matter of us making a few phone calls where we can find the right people.

DR. GORDON: Yes. I'm curious if this group knows of organizations.

Effie?

MS. CHOW: The National Commission for the Certification of Acupuncturists and Oriental Medicine. They give a national diplomate in acupuncture and herbal practice. And then the American Association for Oriental Medicine. Those are national bodies in the practice of Oriental medicine and acupuncture.

DR. GORDON: Dean, you were going to --

DR. ORNISH: No. I mean, there are many of these. And we could just compile a list rather than going through them all here. But I mean, this is -- again, we're not the first person to address this issue and we can benefit from the work others have done on that.

DR. GORDON: So, in thinking about it in terms of convention Western medicine, you would suggest we look to licensing boards of physicians or nurses or physical therapists in some -- say more about what you think.

DR. ORNISH: Well, again, I just think that there are people who will pay out-of-pocket for alternative approaches. That's traditionally what's been happening. But I think as this becomes more and more mainstream, a major limiting factor for access is going to be reimbursement. And because we -- through our non profit institute we've trained about 20 some

odd hospitals around the country in our program for reversing heart disease and we've received insurance coverage from about 42, as well as this demonstration project with HCFA.

So, having spent many years now talking with third party payors, there's a consistent voice that they have, which is we are afraid to cover alternative approaches because, in the case of HCFA, for example, one of the reasons it took six years of going back and forth with them before they finally agreed to do a demonstration project, they said we're comfortable covering procedures. We can get our arms around that. There's less potential for fraud and abuse. But even there we have to deal with that. But once we start covering any kind of alternative approaches, we're opening a Pandora's box.

The phrase Pandora's box I hear over and over again because it's a slippery slope. You know, once we start covering Yoga for reversing heart disease programs, then everybody's going to claim they're a Yoga teacher and hang out a shingle and want reimbursement from HCFA or from a third party payor.

So I just know how sensitive the issue is for third party payors regarding the issue of credentialing and certification. Which really for them is a way of

how can we limit fraud and abuse and provide quality approaches without getting ripped off. And the other issue is reimbursement.

And so if we really want to mainstream complementary and alterative medicine, we have to mainstream reimbursement. And for that we have to address this issue.

DR. GORDON: Great. Thank you.

Are there other comments?

DR. PAZ: Well, one of the things I was thinking about also moving on with is not just with getting the licensure and such, which is very necessary, but also opening up the hospitals to some of these other alternative medicines, too, that currently don't allow that.

One time I tried to get a chiropractor in to go see one of my patients because physical therapy was not having any success, and that was impossible. I was impossible. They had to wait until they were an outpatient before they went to go see them.

DR. GORDON: So issues of credentialing in institutions.

DR. PAZ: Exactly. In institutions. So maybe hearing from HCFA and seeing how we might be able to open that up a little bit more once we do get the

credentialing.

DR. GORDON: Great. Thank you.

Others?

Yes, Tom.

MR. CHAPPELL: Two other specific resources for this subject. One would be the Herb Research Foundation in Boulder, Colorado and a person who's been intimately involved with all the issues of regulatory matters is Nancy Buck of Buck, Beardsley here in Washington. She's been with the FDA. She works on FDA/FTC matters. She'd be a great resources to have in a panel.

DR. GORDON: Thank you.

Effie?

MS. CHOW: I want to go back to a more general issue about --

DR. GORDON: You've got to come close to the mike.

MS. CHOW: Sorry.

I want to go back to a more general issue about access and credential and all that.

CAM is so broad. When we talk about credentialing, I think we have to review all the different practices of CAM. Some bears credentialing. But like exercise, how do you credential exercise and

dealing with the mind, practices dealing with the mind, and products.

I think things dealing with the mind and the spirit, credentialing is different, or regulation, and licensure and regulation is different from products.

And so I think we need to look at all the different aspects of CAM and maybe do an assessment of what is critical to credentialing and setting priorities as to licensure or regulation instead of talking about CAM as a whole and licensure.

And then also, I'd like to caution that when we talk about regulation, sometimes we regulate the effect out of the system. And we need to be aware of that.

I am for licensuring, credentialing and getting standards of practice and all that. But sometimes we're too zealous and jump ahead of the gun.

Just again, an example with Qi Gong. There's over 5,000 different styles of Qi Gong and we are dealing with this. We've set up the World Qi Gong Federation and the American Qi Gong Association and so forth and tried to deal with that.

And also, when it's so new, the products or the practice is so new to the public that most of the public don't even know it. Then an educational

component is really necessary.

But just using Qi Gong as an example, like for us was -- you know, sort of like, wow, Qi Gong. But it's only a small percentage of the population yet that knows Qi Gong.

Yoga is better know because it's been around for a long time. Tai Chi is known because the Southerners came and they have been practicing Tai Chi for a long time. And nobody knows that Tai Chi is part of Qi Gong.

So these are things we would need to consider before rushing into talking about licensuring and regulation. I just want to bring that forth.

And then we squeeze it into a medical model. I'm fearful of that. That we then get into the mistake of squeezing it into a medical model and really squeeze the death out of the effectiveness.

DR. GORDON: Okay. Thank you.

George?

MR. DEVRIES: In terms of credentialing, NCQA does credentialing in chiropractic but really hasn't taken the broad brush on CAM yet. The American Accreditation Health Care Commission and URAC. Their president, and I'm escaping his name right now, but I think he'd be a good one to invite to testify because

they have really looked more in depth at credentialing related to CAM. But NCQA may be in process on that.

On the regulatory side, in terms of creating reimbursement systems ultimately they're going to have to be benefit programs that are approved by state regulators at the department of insurance or whoever is the regulator. And I'd suggest maybe we look at California and Washington, which have been more progressive in terms of covering CAM.

And specifically in California, Suzanne Chammout is the regulator over CAM programs at the Department of Managed Care and Department of Corporations. And up in the state of Washington, Laurie Belinsky.

And then I would just make one other suggestion that we consider. As you're looking at access to dietary supplements which would be herbal supplements, vitamins, right now there's a challenge in terms of how the tax code is written for employee benefits plans that products have to be basically determined to be medically necessary for coverage. And there's actually a bill here in Washington that I believe would correct that, House Bill 3306.

And basically what it would allow is that it would be more on the focus of wellness and prevention,

which is basically saying that employers could create a benefit program for vitamins and herbal supplements and it would be basically -- it would be tax deductible for the employer and that members could have access to vitamin and herbal supplement benefits without being taxed as personal compensation for those benefits.

And this would be allowed without the determination of -- or shall we say it doesn't have to be referred as medically necessary. The challenge right now in our tax code with referring those as medically necessary, it runs right in the face of what Tom was saying earlier, the DSHEA laws and some of the challenges there in terms of saying that this product is medically necessary for this condition.

So that House Bill 3306 we might want to look at.

DR. GORDON: Who introduced the bill?

MR. DEVRIES: Congressman Burton.

DR. GORDON: Okay. Thank you.

Dean?

DR. ORNISH: Well, I think one of the advantages of working with the kind of mainstream organizations that George has talked about is that it makes it much easier then to mainstream complementary and alterative medicine therapies, both in terms of

getting reimbursement and also getting away from the polarization and the sense of adversarial relationships that have often occurred.

And I think there's a window of opportunity now where there's a receptivity in many of the credentialing organizations that there wouldn't have been a year or two ago. And in a way, the Presidential Commission itself gives more legitimacy to that approach.

So I think inviting these representatives of mainstream credentialing organizations, not only can we learn about the process of credentialing but we can also perhaps facilitate them becoming part of the credentialing bodies.

The down side to that is that many alternative practitioners may feel like they're going to lose the creativity or the differences or the spark or whatever you want to call that. But I think those are issues that can be dealt with. And I think the advantages probably outweigh those disadvantages.

DR. GORDON: Thanks.

Joe?

DR. FINS: Just to look forward to where this might all take us, and the issue comes up at the risk of medicalizing it, of malpractice issues and then the

legal and tort liabilities that are related to this.

If we think about what constitutes malpractice in the medical sense, it's based on a deviation from community standards. And I think sort of figuring out what are the community standards and the heterogeneity of practices, I think the legal ramifications are a mess. And the possibility -- I understand right now there's not a lot of litigation in this area, but as expectations increase about these things being more mainstream, expectations could be heightened. Disappointment could be greater. And it could result in malpractice kinds of concerns.

And as far as access is concerned, that could be a real disincentive to dissemination and providers of these practices may have to incur costs of insurance that are not within their current budget or scope of operations.

So I don't have the answers to this but these I think are issues that we just have to anticipate as cropping up.

DR. GORDON: Who would you like -- who or what agencies would you like to hear on this?

DR. FINS: Well, George and I were talking about this earlier and he has some excellent suggestions about this, about people who might be able

to give good testimony on this.

MR. DEVRIES: There's a couple of attorneys that I'm familiar with. One operates a malpractice carrier for chiropractic and acupuncture nationally. And there's another attorney who was a deputy chief commissioner of the Department of Corporations in California and has been very involved with CAM as well as working with medical health plans and I think they have broad perspectives in this area.

DR. GORDON: Let me raise -- that sounds great. Let me raise an issue in this connection and just get your reactions to it.

My judgment is that the whole malpractice system is totally inefficient and corrupt. That's just a small observation. And that there are countries that separate the discipline of physicians or other health care professional from financial awards, like Norway and New Zealand, for example, and set up a fund so that if I do something terrible to you, you get money from the fund. And if I've done it once, I get reeducated. If I've done it twice, I may get my license suspended. If I do it three times, I go to jail.

But there's a complete separation between the financial issue and my issue of competence as a practitioner.

And I'm wondering if people are interested in taking a look at some of those. Because as long as malpractice is the way it is, at least what's happened is people who are truly malpracticed on usually -- I mean, the studies that have been done, the famous New York State Study, they don't get compensated. And many of the people who do get compensated in an independent board's vision, have not had malpractice.

So I'm wondering if we want to take a look at a more intelligent and humane way of doing malpractice. I'm just curious about your reactions to it.

DR. FINS: I would agree. I think we have a system that people on both sides of the aisle and throughout the spectrum think is troubled. We don't have a problem yet in this arena so we have the potential of creating a new model of responsibility and compensation when there are problems that may be less adversarial, more into conflict resolution, more in the lines of CQI that you suggest. And maybe it could be one of those little areas where we could model best practices on a smaller scale for the rest of the health care system.

So I would totally concur with your vision there.

DR. GORDON: What about others? This is a big

question. I did want to get some other input before we put that in the hopper.

Other reactions to it?

Julia?

MS. SCOTT: I think generally I concur also. I think in this whole area, the Commission has an opportunity to look at these issues in a different way and I think we should really grab that opportunity and really think outside of the box, because many of us feel as if our medical system has really failed us as a nation and it doesn't seem to be getting any better. There are little Band-Aids here and there. And I think CAM offers us an opportunity to change our mindset from an illness perspective and crisis perspective to a wellness perspective.

And I think we have a wonderful opportunity to think outside of the box and to avoid the medical model and malpractice, obviously, with all that brings, where no one really is a winner, unless you have a lot of money and can get a lot of lawyers for you.

So I would just encourage us always to try to step outside the box and do that and to not forget as we're bringing in these experts to bring in the experts of people who are experiencing these alternatives, to not relegate them to another position.

I want to kind of reaffirm what Effie was saying, that many times these are cast as anecdotal, but again, if we could try to get some qualitative research done here that really speaks to how these therapies are affecting people's lives and their wellness, I think that would be a good recommendation from the Commission.

DR. GORDON: Thank you.

Dean?

DR. ORNISH: I think on a related note there may be -- actually, there's a trend towards -- I'm not in favor of litigation per se but I think there is an increasing trend where people are litigating not for malpractice in the usual sense but for not providing people a full range of treatment options.

Now, for example, if someone's told they need a bypass operation, not even told that if they were willing to change their diet and lifestyle they could accomplish -- or an angioplasty for that matter -- they might be able to accomplish the same objectives without the risks that are inherent in any kind of surgical procedure. And the cost, for that matter.

And just as in many ways litigation was a more powerful tool in dealing with tobacco companies than legislation often was, I think that under the

banner of Freedom of Information and freedom of access and so on, I think this may be a trend that we may be seeing more of.

I'm not saying we should encourage that, but I think we should be mindful of it.

DR. GORDON: At a minimum, you're talking about a kind of -- you're talking about standard of care, in a sense.

DR. ORNISH: Well, I think here again, to the degree that we can mainstream, get good research, good credentialing, good certification, good ways of getting quality assurance, as these approaches become more mainstream then it will require more traditional allopathic physicians, for example, to make sure in terms of informed consent that when you're signing informed consent you're not only aware that you might get a stroke if you have an operation and all the various things that happen, side effects from medications and any kind of incremental treatment, but that you have other options that many people are not aware of.

And some of the informed decisionmaking that has been done by people like John Wenver at --

DR. GORDON: Dartmouth.

DR. ORNISH: -- Dartmouth. Thank you. On,

for example, use of transurethra resection of the prostate for prostatic hypertrophy, have shown that just giving people the information is so powerful.

I mean, for example, in the area that I know more about in the case of bypass surgery and angioplasty, if you actually look at the data, there really are no randomized controlled trials that have even been conducted to see whether angioplasty prolongs live or prevents cardiac events.

There have been trials of bypass surgery. You find in virtually every one of them that unless you have a very small subset of about 2 percent of people who have left main disease and poor left ventricular function, bypass surgery does not prolong life or prevent cardiac events. And yet we spent $23 billion last year on bypass surgery and angioplasty. And yet also we know if people are willing to make intensive changes in diet and lifestyle, they can achieve comparable reductions in angina. And rather than getting a quick fix that tends to re-occlude or resynose, they tend to get better and better over time.

Now, most people when they go to the doctor and they have chest pain and they are found to have coronary artery disease, don't know those data. They're told, Mr. Jones or Ms. Smith, you need a bypass

or an angioplasty and you can die. That's their choice. And they don't know that they even have other options.

So I think that if we can combine the science, the credentialing, the quality assurance and the reimbursement, then we're going to find that it will be necessary for patients to be given truly informed decisionmaking which most patients really don't have the access to.

DR. GORDON: Thank you. I think that's very helpful.

Yes. Tom and Joe.

MR. CHAPPELL: The more we talk about our difficulties of fitting the practices and mindset of CAM into existing governmental regulatory thinking, the more it's clear to me that we really, as part of this assignment, need to define our world view and our beliefs as a group. And I'm thinking that that could be a fifth group, a fifth category. We have four categories that we've been asked to express an interest in.

This world view or, that is, the beliefs that we have here really has to precede anything that we ultimately produce. It has to be a precept. Because it's an orientation that is different from a Western

orientation.

So my suggestion is that we deal with that as a fifth piece of work.

DR. GORDON: Does that seem appropriate to other people as well? I just want to check.

(All nod yes.)

Okay. Good. Thank you.

MR. ROLIN: Jim, could I just ask a question?

DR. GORDON: Sure. Turn on your microphone.

MR. ROLIN: Thank you.

How do we pursue or determine -- because we've heard examples already of practices that we know that work? How do we pursue and know to what other countries that we look to for the CAM process, how do we determine that? I've heard the names of experts that have been mentioned here this morning. That's surely not all of the resources. I know there has to be plenty others out there.

But how do we as a Commission pursue that? And that's a concern I have. And I agree with Tom in what he has just said there. We need to -- perhaps as a fifth issue assign and determine that. But I do have that question.

I don't know if we have the answer but I'd

certainly have that concern.

DR. GORDON: I think part of -- one of the reasons that Steve handed out the Chantilly Report is to give a sense -- it was a number of years ago now -- a sense of a consensus that existed at that point anyway about what we know. I don't think that in one report that there's anything that's quite comparable.

There are several books that attempt to give -- sort of state an overview of the state of the art. Ken Pelletier's book, for example, is one that talks about the state of the art. It's called "Alternative Medicine: What Works." I do something similar in my book, in "Manifesto for a New Medicine."

And then there are probably others. And then there are specific ones for different issues. For example, Dean's overview of the cardiovascular disease situation is a very interesting one. Wayne Jonas's book on homeopathy talks about homeopathy. There are books on herbalism.

So it's not -- the Chantilly Report really pulls together the state of the art. I don't think that we can -- that's such a huge task. And I think I'm open to hearing other thoughts.

I think what we need to do is sort of to all, as best we can, inform ourselves about the state of the

art and especially about those areas that we don't know much about and get an overview of them and then come together. Because if we try to pull together a state of the art, we're going to be so overwhelmingly focused on that that we're not going to get back to the task at hand.

But I think we can bring in experts where we feel it's particularly important to testify in exactly this section, the section that we're talking about now, about the state of the art in different areas. So I think we need to be thinking some about which areas we really want more information about and that we feel we're missing that information.

Steve, do you want to address that?

MR. GROFT: And I think what will happen also, we'll have the opportunity after this meeting to get the working group together to discuss how we want to approach, who we want to invite, and things like that. So just getting the ideas and then the feedback from the Commission will give us the opportunity to put the program right.

And we're looking at maybe three or four months down the road as far as holding the discussion on this issue. So we do have time to work up an adequate agenda with speakers, and even to do some

thorough literature searches and then to make a pretty good presentation to you on the whole issue.

DR. GORDON: That's very important, Steve.

One of the things that Steve mentioned at the beginning is that we're in a position, if there's an area that people really want that information about, we can actually, instead of just calling in a witness, we can hire someone to do exactly that piece of work that we want done. So that's something -- thank you for adding that -- something to be thinking about.

Joe?

DR. FINS: At a sort of meta level, I think we all agree we need greater access. But the question that I think is related to what Buford was saying is access to what. And we obviously can't pay for everything. And third party payors can't pay for everything. The government can't pay for everything.

So I think one of the things that might be very helpful for us strategically to begin to talk about is the issue of priority setting. What is absolutely must be covered. What is a second tier thing and what is -- you know, in a pie in the sky universe, what would we cover.

And I think there's a very interesting parallel that happened in Oregon with the construction

of the Oregon plan, which was their way of having diagnosis and treatment pairs and a ranking list. And historically -- initially they covered a bunch of medical interventions. Then they went around and had town meetings of the sort that I think we envision and they found out that mental health services were very, very important to the population, as were other things that were lower down the lists, like assisted reproduction, that on a purely utilitarian basis should have been lower, but it was important to the populace so it rose higher in the list.

So I think that the notion of engaging and setting priorities and making it based on the medical and scientific facts as well as the communities values and what the people want and desire is a challenge that I think would help us design a credible list of things that will be accessible within budgetary constraints.

DR. GORDON: One of the things that Michele was just pointing out is that in Wayne's notes he mentions that there are several states that are already grappling with which services should be integrated. And we should consult people in those states. I think that's a good idea.

This is obviously a very important question.

MS. CHANG: Jim, if I could just add. This is

the paper that we passed out yesterday because Wayne couldn't be here. And that was one of the points he had on the back end of that. And he gave us for today some more examples of what he was talking about from Bastyr in particular. So those were put in your place this morning. At your leisure, take a look at them. And we'll follow up with that at the next meeting when Wayne's here.

DR. GORDON: Great. Thank you.

Effie?

MS. CHOW: Yes. Reinforcing what has been stated, I think we should keep our vision in mind here. The Commission is new and it is in view of our country and the world. And I think the world will look to us as an example of what can happen with CAM.

I do encourage us to keep the vision that we can create a new system of really health care. It has been said that our system is not Department of Health and Human Services. Department of Illness and Human Services. And the National Institutes -- not Health, but of Illness.

So I think we must keep that vision in mind. We can use the same terminology as the regulation or maybe create new terms for regulation credentialing and all that is necessary. And then there are lots of

samples.

And I really do think, James, your suggestion about looking at other countries for examples of integration. For example, in Chinese medicine, China is integrated well. And the Swedish and Norway examples are really good.

DR. GORDON: One thing I want to add is I think it's important not only to look at what states are doing but it's very important to look at some model programs. And I think that there's an aliveness and a vitality that comes with specific programs that can really be inspiring. And I think that will give us a sense of how this process of integration can go on.

So I'm hoping that we'll call at least a few people.

And, Dean, you're here, but I hope you'll talk to us about your program because yours is clearly one of the models of a way to integrate a number of different therapies that's effective and that's cost effective as well. And I think that we can find a few other programs as well that will be inspiring.

MS. CHOW: Can I just make one more comment?

DR. GORDON: Yes.

MS. CHOW: It's that we have to also remember that our medical system is based a lot on economics

unfortunately, and that we don't want to get caught into that. And also, that when the CAM, it might get caught into the economic --

DR. GORDON: What?

MS. CHOW: CAM might get caught up into the economic basis.

One of my worries about the popularity of CAM is the fact that the studies are showing that 17 point something billion dollars a year in the 1960's study and now more recent studies are saying that it's 30 something billion dollar and 40 something billion dollars a year.

I mean, that's a great incentive for medical institutions and medical doctors to get into it. I know there's great idealism to the institutions and the doctors but there are many that are getting in it just because of the economic level. And I think we need to address that. We need to.

DR. GORDON: I want to say one word about that and then, Bill, let you have the mike.

I think it's very important that we preserve the spirit of this work. And this is following up on what you're saying. It's not just the practices. Within five to 10 years most major medical institutions are going to have some kind of program of CAM. I think

the issue for us is what's that going to be like. What's the feeling going to be like. What is the spirit going to be, one, of encouraging health and self sufficiency and creativity or is it simply going to be another medical service. And I think we need to address that head on as a group.

Bill?

DR. FAIR: I think one concrete thing this Committee can do along the lines of this morning's discussion is to follow up on the comment Dean made about informed consent.

Joe and I were talking about this last night. It's true that speaking of heart disease that the options, lifestyle and dietary changes, are generally not mentioned as something else that's an alternative. It's even more true in the area of cancer therapy. And I speak now as a patient and not as a physician.

I see this so many times. It was true in my case. This is the only thing we can do. And yet we have studies were David Spiegel, for instance, has shown that group support will double the survival time with women with breast cancer. And how many times have we heard -- and it's still going on today -- women being told they need autologous bone marrow transplant for breast cancer, despite the cost and the toxicity.

And four studies now showing it has absolutely not benefit, yet sometimes these poor women are told this is the only thing we can do.

Insurance companies have been sued to provide for this procedure despite having scientific evidence it doesn't work. And it still goes on.

And I think as a cancer patient, I would just like to say we never reach a point where we can do nothing. And I think that that should be a very clear recommendation from this Committee. That physicians should be aware of the fact that we never reach that point when there's nothing we can offer for the patient.

And I think following up what Effie said, I as a physician now think that the answer is purely economics that are driving this. I think it's our training. We're always trained to do something. Physicians aren't just supposed to say I'm sorry, we can't do anything.

So we feel that whatever it is, whether it's a bone marrow transplantation or heart surgery or whatever, we're trained to do something. And I think that that to me seems to be the overriding factor in some of these last ditch efforts.

But I think that if we just got that message

across to the American public and to the American physicians that we can always do something no matter what the condition is, that we would create a great service.

MS. CHOW: Excuse me. I just to qualify --

DR. GORDON: We're going to come back at length to that in number four a little bit later. But thanks.

MS. CHOW: I just want to make a comment. I think basically -- I want to make it clear. I think basically the aim and the spirit of the physicians are good, except for the education. And that's where our mission to educate the physicians, the nurses and all the medical people into a broader field of thinking. So that is --

DR. GORDON: I think we're on the same page.

MS. CHOW: Yes. They're wonderful. And they can only do what they know. And we must take that stance. And we must take a positive stance.

In my approach, we've always not sort of down dragged the other person. So that education is our mission.

DR. GORDON: Dean. And then George. And then I'd like to wrap up this section unless there's anything specifically focused on this section and take

a little break. But Dean and George first.

DR. ORNISH: Well, again, I do think that a primary determinant of medical practice is reimbursement. I used to think it was just science. But as we've talked about, we've actually looked at examples. Even when the science isn't there, people are still doing it. And many of the same interventional cardiologists who were so critical of bypass surgeons for doing bypass surgery for many years without having done any randomized trials have yet to do a randomized trial. I don't even know that any are even in the works.

And on the other side of the coin, I think one of the reasons that this Commission is meeting today is because there's a growing awareness that so much money is being spent out of pocket for alternative approaches.

And so I think that in one sense there's a Catch 22 that certainly we experienced in our earlier stages of trying to do research is that it was very hard to get funding to do alternative interventions from mainstream organizations because there was a preconceived idea that they were ineffectual. Without the funding, you can't do studies to see whether something works. And if they don't think it's going to

work, they don't fund it.

And so I think that we keep coming back to the area of doing really good science but also the areas of reimbursement.

There was a well known editorial in the New England Journal of Medicine a few years ago I sure you saw where they said, you know, we really need to get away from thinking about is it alternative or is it conventional to does it work or doesn't it. And if it works, then people will use it and it will be reimbursed. And if it doesn't work, then it won't.

And on the surface, I completely agree with that. But for that argument to be cogent, we really have to make sure that we have enough science and enough reimbursement to make these therapies -- to adequately test these therapies and to hold the same standard to the more conventional therapies. If they don't work, then we shouldn't be using them either. And if we don't know yet, then they should be studied and held to the same accountability.

DR. GORDON: Now, to address that, it might be useful to call somebody like -- ask somebody like Wennver to come?

DR. ORNISH: I think having Wennver come wouldn't be a bad idea. I think having Arnold Relman

come and, as I talked about yesterday, some of the more severe critics of integrative medicine and alternative medicine so that we can both benefit from their perspective and address it.

DR. GORDON: Great. Thank you.

George.

DR. BERNIER: We spent a large amount of time yesterday on the research enterprise. And it would seem to me that when we're talking about licensure and credentialing that it's going to be based to a degree upon what is found in the research enterprise. And I just want to plug that research end of things.

The more secure we can be about the validity of something the more likely we will be, I think, to be able to develop good guidelines for licensure or credentialing.

DR. GORDON: Great. Thank you very much.

Let's take a 15 minute break and then we'll come back and move on to the next one, the provision of information.

(Whereupon, a recess was taken.)

DR. GORDON: Let's move on to the third of our topics. We're doing so well that -- Steve and I were just doing some calculations at the break and we should be finished by 3:00 or 3:30. So everybody will be able

to -- just about everybody will be able to make the earlier connection. Because what we're doing, we're really doing our task and we happen to be doing it very efficiently, which is nice. So I appreciate it.

Let's move on to number -- yes, Tom?

MR. CHAPPELL: I'm sorry. I just wanted to get clarification of this suggestion of a fifth working piece on beliefs and world view. And since I understand there's a working order to our focus, I believe that this should be the first piece that we work on because the sooner we set up our understanding of how we relate to all of these four topics through a world view or a belief system, the more easily we'll be, the more comfortable we'll be that everything is fitting into that orientation.

So I wonder if we could just put that together.

DR. GORDON: I would make a somewhat different -- just because I have a sense of the logistics of what needs to be done. That we could set aside some time to work on that during the first -- the next meeting, rather than wait. Because I think we can move ahead with some of the research because a lot of that is gathering information.

MR. CHAPPELL: Well, I think that's a

wonderful suggestion.

DR. GORDON: And we can set aside time for discussion about belief and world view at that meeting. Okay?

MR. CHAPPELL: Thank you.

MR. GROFT: And actually, Tom, at that point we may want to build that into the introduction to the report rather than making it a separate issue or something. We have time to discuss exactly how we want to present it but we'll get it put together.

DR. GORDON: And I see also it's very much of an ongoing discussion as well.

Okay. Let's begin then.

Thank you, Tom, for reminding us of that.

*Number 3, the provision to health care professionals of reliable and useful information about complementary and alternative medicine that can be made readily accessible and understandable to the general public. And I would like to add another piece to that, which is the provision of information directly to the general public as well.

So let's begin with discussing once again what we need to know or how we need to be informed in order to make recommendations in this area.

And you'll notice this is slightly different,

although not altogether different, from number 4, which has the education and training of health care practitioners in complementary and alternative medicine. And I think the separation is a bit artificial but number 4 is more focused on formal training, whether undergraduate or post-graduate. And number 3 is more focused on how do we make available in a more general sense information to all health care professionals and to the public.

Dean.

DR. ORNISH: I'm trying to put this in the context of the fact that we're a White House Commission to advise them on medical policy. And I'm not sure -- which presumes the government's role in this. And I'm not sure what the government's role would be in terms of providing health care professionals with information. I don't quite -- I'm not saying that we shouldn't but I'm not quite sure where the fit is there.

DR. GORDON: Well, I think that we can define what that is. For example, NCCAM has a database. NCI has some papers on specific therapies for cancer, information sheets on specific therapies. Those are two examples.

Conferences are sponsored by NCI and NCCAM

relating to providing information. Our conference for example.

DR. ORNISH: So like a consensus statement. So the NCCAM or NIH or whatever could provide a clearinghouse of consensus statements on best practices or consensus. Like there was, I guess, an NIH consensus statement recently saying that acupuncture had some validity whereas some other treatments didn't.

Is that the kind of thing that you're talking about?

DR. GORDON: Yes. I think we're talking about -- but we're also not only talking about NIH and NCCAM. We're talking about the government as a whole. And we're also talking about recommendations that we can make.

For example, the issue you raised earlier about standard of practice. Doesn't it make sense as we expand the standard of practice, then we need every internist and family physician and cardiologist to know about standard of practice for heart disease. And that's a provision of information.

DR. ORNISH: By whom though?

DR. GORDON: We can make recommendations about that. The Surgeon General provides information about smoking, for example.

And although our major recommendation is for legislation, we can also make other kinds of statements as well. We can make a recommendation that the American Association of Medical Colleges should be providing certain kinds of education or that a specialty board, the special groups should be providing information.

DR. ORNISH: Okay. So even though it may not be a government agency per se that we're recommending do it, we could still include other agencies in that?

DR. GORDON: Right. And I think our major task right now is to consider both what the information, the kinds of information that should be out there, and then as well who should be providing that information.

MR. GROFT: I think one of the things we can think about as we go about these public meetings, one of the questions we would want to entertain would be what are the needs of the health care providers. What are the informational needs. And focus some of the discussions at these town meetings throughout the country and have them address those issues as we go around. And I think we'll start to get a feel for what it is that they say they need to integrate these practices into their practice and just expand from

there.

So we do have the opportunity to capture that information. And I think what we'll find after we go through two or three town meetings, some of the information will be repeating itself and you'll get a pretty good idea and feel for what is necessary.

DR. GORDON: Great.

DR. PAZ: One of my concerns on that is that sometimes on these town meetings you attract the people who know a lot about it and may not get to the folks that really don't know much about it. So sometimes some of that information needs to be even more basic than what some of these folks might want.

DR. GORDON: Do you want to give some examples of that? Because I think that that will be very helpful as we think through this.

DR. PAZ: What I'm thinking about is that there's actually a lot of folks that have no information or really don't even know anything about how acupuncture might work, how some of these other therapies might work.

So even getting out information as far as their philosophy, not just technique but also their philosophy on that.

DR. GORDON: Thank you.

I have an even more basic concern which is part of this. I feel like children don't have a clue how they work. They don't really -- nobody teaches them anything about how the mind works or how the body works really. Health is focused basically on a few diseases or smoking. And I think part of the way I see part of our mission and a lot of the work which I can describe at some other point that we've done has been working with school kids here and in other countries teaching them some things about themselves and encouraging them to learn about themselves.

And I think that we can make those kinds of recommendations as well. My basic point -- and this comes back I suppose to philosophy -- is that if you become aware of your capacity to understand yourself and to take care of yourself, then your view of the options and your view of the standard of care is altogether different than if you think it's just a doctor who knows something about you.

So this world view and this perspective and this philosophy to me seems to me to need to be integrated into the provision of information, too.

Bill?

DR. FAIR: To follow up on that though, I'd like your thoughts. I agree with you completely that

the time to get the message out is to children. That's the ideal way. But if you look at the incidence of smoking among -- particularly among young women now, that whole approach is rather -- the results of that approach is rather discouraging and the smoking cessation programs in the school.

I wondered if you would expand on that a little bit. What's a better way to get to the children?

DR. GORDON: Well, I just talked for a minute. I'm happy to expatiate at length. But I think the issue -- I never tell kids not to smoke. I say what's it like smoking. Smoke meditatively. I'm serious about this.

What does it feel like to smoke? Pay attention to the smoke. Really enjoy the cigarette.

And often as you start to get into that experience of what it's like to smoke it becomes clear how destructive it is to you. That you may enjoy it for a while but at a certain point --

I think the message for me is not telling people what to do or what not to do but creating an opportunity for them to use their intelligence and use their intuition and use their own physical experience to discover what feels right and what doesn't feel

right.

The same with diet. I work with kids a lot with changing diets. Most doctors have a very difficult time. It's not that it's easy. But I say to the kids are you willing to do an experiment. It's the difference between telling a kid don't do this, do that, and saying are you willing for two weeks to not eat this, this and this that I think you may be sensitive to in some way. And the kids will always say, two weeks? My god. I'm not going to have a candy bar for two -- or whatever it is.

They do it. They feel better generally. And then they go off the diet and I say how do you feel.

So I see this as a true -- education is a process of discovery and I think that part of what we can do -- and I certainly don't have all the answers. I just happen to know the ways that have worked -- is to begin to create -- to actually turn kids into scientists and good observers of themselves and of their own experience. And that that's sort of part of my work as somebody who integrates CAM into my practice.

DR. FAIR: That might be important to incorporate in whatever statement. Yes, it's important to get children, but we have some questions about the

current methodology really getting the message across. And we might consider other ways of doing that.

DR. GORDON: Great.

Joe? Joe, Tom and then Effie.

DR. FINS: I would like a paper commissioned by someone who does media studies in one of the journalism schools to look at the quality of the public's information about complementary and alternative medicine.

What are the sources of information that they actually rely upon, from TV to your wonderful parents this morning to other sources, to talk radio, to the various magazines.

Also, how available is this information to the entire U.S. population as far as literacy, bilingual issues. What is in the Chinese-American press? What is in the other languages that make us such a rich and diverse country.

So I'd like to know what the sources are and how credible and reliable they are because I think that again, to get back to something that was said yesterday, there's a tremendous heterogeneity of practices, and some of which have liability. Some have tremendous benefits.

So I'd like to know what --

DR. GORDON: As kind of a baseline of what's happening.

DR. FINS: Baseline of what's out there.

DR. GORDON: Okay. Great.

DR. FINS: I think we would be able to build upon it and make it even more reliable and useful.

DR. GORDON: Terrific. Thank you, Tom.

MR. CHAPPELL: I'm very excited about your suggestion about a focus on children. And I just wanted to affirm that and to build on it a little bit.

Again, in the illness model, the authority is the doctor. In the wellness model, the authority is the person. It's a very important shift in thinking.

When you begin to think about children and how do they come to know about their bodies or their health, the first contact with this question really is when they're dealing with sexuality and all the issues of sex at school. And I think there is an opportunity to bring the notion of health is your program to children at a very young age.

And if we really need any reinforcement of that mindset, we could invite some of the addiction recovery experts to testify about how recovery is the individual's program. The authority is the person, not the doctor. And it's quite a shift in thinking.

DR. GORDON: Great. Thank you.

Effie?

MS. CHOW: If we're talking about CAM as really a life system promoting health and life, then it's for all ages. And so the focus is different for all ages, from the very young to the seniors and in utero, too. You are born. How do you treat your pregnancy.

And so I agree. I think we need to do an inquiry with town halls as to what is needed. We can assume what is needed from our own experiences but I think that's just an assumption from a small segment.

And right now though people need information. So whatever we have, we should make it available to the public. And I know NCCAM has some sort of a clearinghouse, complete or not complete, but more people should know about it. And more people should known that NCCAM exists. Many people don't. People from the systems don't know that NCCAM exists. I'm always surprised.

And I think that the children is really a very important area because they're going to be the citizens of tomorrow. And breaking habits are more difficult than forming habits. And that is for life.

I think that we should focus on the youth.

DR. GORDON: Thank you.

We can find out what NCCAM is doing. All of this is probably not going to be within their province or their mandate. So I think that we're going -- and we can certainly ask Steve Strauss what he sees NCCAM as doing. But my bet is there's going to be a lot of this that's going to fall into other categories.

MS. CHOW: I'm just talking about the information, the clearinghouse of information they have.

DR. GORDON: What I'm saying is we can find out what they are doing.

MS. CHOW: Yes.

DR. GORDON: And that clearinghouse, I doubt is -- I think their focus is on research. I don't know that they're going to be prepared -- and this is really just a question. I just don't know.

MS. CHOW: I think that's one of the first order is to find out --

DR. GORDON: I'm sorry?

MS. CHOW: I think that's one of the first orders to find out what is available and what's good in assessing.

DR. GORDON: Good.

MR. GROFT: And I think one of the

responsibilities --

MS. CHOW: I mean, generally. Not just NCCAM.

MR. GROFT: I think one of the responsibilities of NCCAM and the information at the center is to provide information about alternative treatments. So I believe there was specific language put into appropriations bills in the years past when they set up -- gave them direction to set up the information center. And that was several years ago, if I recall.

I think a quick look at their website and the information center I think you would find it. But we will have that presented from Dr. Strauss and others at the time of the next meeting.

DR. GORDON: And the other issue is it's treatments. And what I'm hearing is we want to expand that mandate. That it's not just about treatments. It's about more general kind of health education.

Joe?

DR. FINS: I think we should also look at exploring and fostering collaboration and outreach with the disease advocacy groups. So if someone has prostate cancer, they're not necessarily going to first look at a CAM website. They might go to a prostate cancer support group and hear from the major illnesses

and find out what they do disseminate as far as complementary and alternative medicine modalities and how there could be a partnership with them to bring information to those patient populations.

DR. GORDON: That's a great idea. Has there been a disease advocacy group that you think is doing this in a model way at this point?

DR. FINS: Well, I think the Komen - the breast cancer with Susan Komen -- you know, Race For the Cure, might be a good place to start. I think they're very sympathetic to a holistic approach and they may be a good place to begin this.

DR. GORDON: It would be great to have them in. I just worked on the review panel for them and they're at the very early stages of it.

I'm wondering if there is a group that anyone knows of, just off the top of your head, that really has come a long way in this process of providing kind of integrative education. Anyone know of any?

(No response.)

MR. GROFT: I think the Tourettes Syndrome group has had some interest in this for a number of years because of possible interventions. I just received a call from someone from Neurofibromytosis, Inc. about complementary and alternative medicine. So

I think there are some organizations that have thought about this.

In fact, the word I was getting is that there's a greater interest in finding out more and more what might be available to them. So I think we can easily pull them in.

DR. GORDON: So we could bring in some that are already there and then we can bring in some of the larger ones and ask them how they're looking at the issue. Terrific.

Dean.

DR. ORNISH: I've been working with Web M.D. for the past few months and they, I think, provide an example of using the internet to provide these kinds of educational information to both health professionals and to the general public. And the whole opportunity of using the internet to provide this information to people I think is really something that we should explore. And it might be useful to invite some of the people from Web M.D. and other internet health providers so that we can explore what possibilities are there.

DR. GORDON: Terrific. Thank you.

Effie.

MS. CHOW: The Cancer Society in San Francisco

has sponsored alternative medicine programs and also the American Heart Association.

I think many of the major programs -- I say this because I have spoken to those groups and it may be isolated events. But I think they're interested. And I think if we made an effort to approach all these organizations, they're very open.

DR. GORDON: Great.

Joe.

DR. FINS: Another one that comes to mind is the International Hospice Organization and the panoply of work that's being done at the end of life.

One of the things that strikes me is just how this Venn diagram, which should be overlapping, doesn't. And you would think that people in different areas were talking to each other and they're not.

We have to remember that patients, their care, should not be venue dependent. It shouldn't depend upon where they start. It should be continuous.

So I think building these kinds of linkages would really help and really address not only information but access, which is our previous theme.

DR. GORDON: How about information -- a lot of what we've been focusing on I think applies a little more to information for the public. What about

information for the health professionals? What shift? That is, all those folks who are out in practice right now.

DR. ORNISH: Here again, places like Levandy are trying to integrate physicians and other health professionals, nurses and so on, with people in the general public with third party payor reimbursement. And through companies like that -- and there are others -- I think there's an opportunity to reach health professionals with this kind of information in ways that don't require them to take three days off from work and go to a CME conference and so on that ultimately can reach a much larger group of people must more cost effectively.

DR. GORDON: Other thoughts about this?

Steve.

MR. GROFT: I think it was Dean yesterday who mentioned about the medical journals and what's required to get articles published in many of the medical journals. So we probably would want to try to bring them in to discuss this issue, as well.

DR. GORDON: Yes.

George.

MR. DEVRIES: Micro Medics has produced a professional -- and this is an online resource for

providers, Altmeddex, which has accessed information on complementary health care, herbal supplements, vitamins. That's one product that's available out there and might be interesting to talk to Micro Medics.

PDR has a similar product for vitamins and herbal supplements and minerals.

Also there's an organization, VICUS.COM, which is really just a new start-up internet, but it was started by some people coming out of Stanford who basically are providing online continuing medical education in complementary and alternative medicine for medical physicians.

And so those are just three that come to mind. Two seem to be sort of out there really trying to create unique educational resources for health providers for medical physicians related to CAM.

DR. GORDON: Effie, did you have your hand up?

MS. CHOW: The continuing education avenue is probably one of the greatest sources, because pharmacists and dentists and physicians and nurses, they all have to have a certain number of continuing education credits to renew their licenses. And we've been involved in that a lot.

There are even funding from agencies for them to get continuing education credits. So I think that's

a strong area if you're asking about the professionals.

DR. GORDON: Dean.

DR. ORNISH: This may be too obvious to mention but it might be worth having people who have set up integrative medicine programs for health professionals, like Brian Berman and others, to come and testify to share their experiences because I'm sure they've been dealing with this issue a lot.

DR. GORDON: That's a great idea.

What we're talking about mostly at this point with regard to health professionals is those people who are already somewhat or quite interested who are looking to these things. People who come to your program, my program, Brian's program, have come to the CME courses.

What I think about in part as I look through the American Journal of Psychiatry or JAMA or the New England Journal, I look at all those ads for conventional medicine. I look at the huge amount of information that's coming just every day in the course of trying to keep up as a professional with what's going on in the profession that's coming about these other -- the conventional approaches.

I'm wondering how we put -- how we begin to put this information out in a way that's -- in a very

much broader way so that all conventional health professionals are more exposed to some of these approaches in ways that may be familiar, may be slightly novel to them. I'm just wondering about that.

DR. ORNISH: I mean, that's what some of these groups are doing already. So I just think that rather than reinventing the wheel, we should hear what's out there.

DR. GORDON: Find out what's happening with the internet companies, for example.

DR. ORNISH: Internet companies, people like Brian Berman, Andrew Weill. Other people are doing targeted continuing education for health professionals of one sort or another. And I think that we should invite some of those people to testify to share what's out there instead of just starting from scratch.

DR. GORDON: Sure.

Effie.

MS. CHOW: Again, it goes to licensing. If we could work with the licensing boards and if indeed we're saying that so many percentage of the medical schools are incorporating programs into their programs, what is the standard there. And also, that if indeed CAM is going to be in all hospitals in the next 10 years, then we'd better start thinking about what is

the minimal training that every professional person should have and instigate it in that way.

DR. GORDON: That's great, Effie.

So one of the things might be to ask people, the National Board of Medical Examiners, the National Board of Nursing Examiners to come and talk with us about how they're going to be or how they already are addressing including these questions.

MS. CHOW: And the states.

DR. GORDON: Great.

Tom.

MR. CHAPPELL: I guess I'm just wondering if the government, through alliances, can't assume the responsibility for education. I appreciate the private sector's employment of these targeted educational efforts but if we have -- with regard to CAM, we have research going on and we have licensing going on, why can't we have a body that is responsible for the dissemination of the content.

And it's not just the content. It's also how do you make that information appealing and transferrable to the various audiences using various media. CD-ROMs.

So I really think this is a big question because the health professionals that I talk to are

learning about CAM on weekends on seminars that are being put on by private or non-profit groups. And then they go to the internet to learn more. So it's a rush job. They're working all week. They've got their education that they got at medical school and this is continuing education. But it's a big piece.

DR. GORDON: One thing perhaps we could do is ask the Surgeon General, ask Dr. Satcher, to come in and talk about what the Surgeon General's approach might be to this whole area. He's the highest official in public health.

MR. CHAPPELL: Wonderful.

DR. GORDON: Joe and then Dean.

DR. FINS: Just another suggestion for another group of entities that we might want to reach out to is the Joint Commission that accredits the hospitals, JACHO. Because I think that one way to address what Tom just said is to really get into the interstices of institutions is to build it into the sort of regulatory expectations of hospitals.

And I think a starting point which would be probably very non threatening would be to simply require as part of the patient standard of care on the history and physical is to ask about whether patients are using these medications or complementary therapies.

Because I think -- I mean, it's not really even the issue of access. It's whether we know what kind of alternative modalities are being used because they're going to have a bearing on drug interaction and the like.

So the Joint Commission, I think, would be a good place to start.

DR. GORDON: Dean.

DR. ORNISH: I like the idea of involving the Surgeon General and, for that matter, the Centers for Disease Control and other organizations, national boards and so on. Because not only do we learn from their experiences but we involve them in the process. And I think it's like anything. When somebody gets involved in the process, then they become much more a part of that process rather than being threatened by it. And so I think we can accomplish a dual objective there.

DR. GORDON: Great. Thank you.

Any other comments on this issue of provision of information to health care professionals and to the general public?

Joe.

DR. FINS: Steve McPhee in San Francisco recently did a study with a bunch of others looking at

the palliative care content in major medical textbooks. And it might be reasonable to really get a sense of what is in those books.

DR. GORDON: That's great idea.

DR. FINS: And I know it sort of seques into the next item, but to really know what is covered in the Standard Harrison's, the CECILS, if there is any content, which I think would be a very interesting study to commission or help promote, because it would just illustrate how little there really is in the mainstream that needs to be amplified.

DR. GORDON: That idea is appealing?

(All nod yes.)

Yes. Okay. Great.

Effie?

MS. CHOW: I think that the hiring of people, of staff for positions also include are you familiar with alternative medicine. And that might become a requirement for a health professional to have some exposure to CAM in the hiring process, too, as well, down the way. Not tomorrow but down the way.

So I see it going through the whole system actually. That in the basic schools, the schools of medicine, they're having elective courses on CAM but it might be a required course.

DR. GORDON: We're going to come to the sort of medical professional education in a moment. We'll come back to that and we can focus on that.

Any more at this point? Suggestions about public education, education of people in practice, education of the general community? Not that we don't have plenty already but I just want to make sure.

Yes, Tom.

MR. CHAPPELL: The schools of pharmacy around the country are doing a lot of this, weekend seminars and training. So we could invite some of those like the University of Illinois at Chicago College of Pharmacy, Harvard. This is going on. This is their practice.

DR. GORDON: You know what that reminds me of is the question about information that's being distributed in both drugstores and also in health food stores.

MR. CHAPPELL: I've been sitting here thinking about it a lot.

DR. GORDON: That's obviously a huge area. And I'd like -- now that it's coming to mind, how would we like to approach that.

MR. CHAPPELL: Well, let me describe the problem first because you've got the person working in

the nutrition aisle who again is constrained as to what he or she can say to the consumer about what the benefits are of these dietary supplements or natural medicines because of the regulatory issues.

So we could bring in leaders of the natural food chains, whether it's Whole Foods or Wild Oats. Those are the two national chains. We could bring in marketers. But generally speaking, this is a very difficult area because consumers are going to the health food stores for solutions but again they have to be self educated.

There's such a thing as third party literature. For instance, if I want to transfer why Echinacea works, I have to produce a third party literature and locate it in the store a certain distance from my product. That's what the law says. I can't put that at point of purchase. I can't put it on the label.

So, I think Nancy Buck would be very helpful in helping us unpack this. I think the health food community. And then -- well, I guess those are -- but I can certainly get you the names of the leaders in the industry to come and talk about this problem.

DR. GORDON: What about the related issue of drugstores and information that's available there?

MR. CHAPPELL: Well, they are focusing right now on the interaction of drugs and herbal and mineral supplements. They're also doing a lot of continuing education with their pharmacists. So, the colleges of pharmacy like UIC are bringing the pharmacists together on weekends so that pharmacists are fulfilling their requirement for ongoing education in this field of complementary medicine.

So we could bring the head of the National Association of Chain Drugstores in. Those are people we know, so --

DR. GORDON: Okay. Great.

Joe.

DR. FINS: On an closely related issue -- and I don't know -- I've never seen it, but it would be really helpful to hear from the PDR people. Not just in the vitamin book but in the main pharmaceutical book, to talk about interactions about drugs. Because I don't think there's a sort of a standardized place, a resource for physicians who are in practice to know about those interactions. And when they're looking up one drug, to know that maybe a botanical may have an impact on the T450 enzyme system.

I think those kind of things really need to be known and put in a place where doctors look for

information.

MR. DEVRIES: To follow up on Joe's comments, Micro Medics has just recently introduced a product, Altcarereact, which is -- basically, it's an online interaction guide between herbal supplements and vitamins with pharmaceutical drugs, alcohol, tobacco and food. And again, Micro Medics might be a good organization to talk to the research they did there because they went into some substantive detail.

DR. GORDON: Great. Thank you.

Effie.

MS. CHOW: I think it's important for people to have access to a piece of literature or a couple of pieces or three pieces of literature that gives them the basis. And there are information existing but we need to assess what might be if we accept some other information.

But I think the Commission could create some basic introductory material that can be given out to the practitioners, the doctors' offices, the hospitals and the associations, et etcetera. Because you say, well, get information. And then, where do we get the information.

So we could create or else find appropriate literature that the Commission can sort of endorse and

make it a distributory piece of information.

MR. GROFT: I don't think that's appropriate for us to do it.

MS. CHOW: No?

MR. GROFT: That's really getting down to a level that we don't want to do. I think we have to keep it as a policy.

MS. CHOW: But as a recommendation?

MR. GROFT: We can make a recommendation that perhaps as an implementation of one of the recommendations that this be followed up by some agency or some other source or something like that, but I don't think we want to get tied up in that. Because then you're starting to look at which ones are you going to do and how many are you going to do. And that's a year.

DR. GORDON: I agree with you, Steve. And I think one thing we can do if we feel this way -- and our town meetings will give us a sense of this as well, although obviously we all have our own sense -- is express a feeling of perhaps urgency about this information.

I know that in the area, Bill and I have been sitting on the Cancer Advisory Panel, and there is a tremendous sense of urgency among cancer patients for

this information. And I think that we've tried to convey this on the panel and others have as well. Perhaps as a group we can convey the importance. That this is not a secondary issue if we indeed feel that way. That this is really quite --

And people do look. When the Office of Alternative Medicine was still an office and I was the chair of that committee, 70 percent of all of our calls, just as an example, were about cancer. And they were basically saying what about this treatment and what about that treatment and where do I go and what do we know.

And I feel, too, that although we should not micro manage it, that the government is really the place of authority in many of these things. And the process of providing information -- sometimes the process is excellent. I mean, the materials coming out of the NCI now I think is very good, but it's so slow. And perhaps if we see this as a higher priority and indicate to Congress that this is a higher priority instead of the sort of few dedicated people who are working on it, there will be more people who are working to provide the information.

MR. GROFT: I think at the same time we have Dr. Strauss come in and speak we probably would want

Dr. Jeffrey White to come in from the Cancer Institute, who's responsible for their program in complementary and alternative medicine and explain what they're doing.

There are considerable resources that are in place to address these issues and I think it would be good to hear from them.

DR. GORDON: We can even ask Dr. Thompson to come because I think he's -- one of the first things that he did when he took office was to reassess the information and to push for better information about cancer therapies.

And, of course, we need the same kind of information about a whole range of other therapies. It's not just cancer.

MS. CHOW: That's the point.

DR. ORNISH: I know that some companies like Medtronic, for example, through their foundation, have funded integrative medicine programs at Stanford, at Scripps, at Harvard and other places. And I think it would be useful both to have members of those programs come because they're set up to be model integrative medicine programs, and also someone from the Medtronic Foundation to come to talk about, A, why they did that; and B, how they might encourage other foundations and

corporations to do something similar.

In fact, they just did a conference here yesterday on patient centered medicine, as an example of the kind of work they're doing.

DR. GORDON: Great. I think that comes more under the category -- I think it's a great idea. It comes more under the category of access and delivery of complementary and alternative medicine services.

DR. ORNISH: It does. But it also includes -- because a lot of these programs are geared towards not only providing services but training health professionals, I think it goes into both.

DR. GORDON: The other thing along that line that I would suggest, too, is that in terms of the delivery of services, Medtronic is a good group to have come. And also that we ask foundations to come and to see how they are supporting the development of different kinds of programs and to encourage the private sector to talk with us about their involvement in a sense in all these issues.

So I think we need sort of a category for that because the government is not the only funder, whether it's of research or of programs.

DR. ORNISH: And along the same lines, High Mark, which is Blue Cross Blue Shield of Pennsylvania,

has not only been covering our program but been providing it and is now training other groups to do that as well. So that's an example of how third party payors can go beyond just reimbursing alternative approaches but actually be providers of it.

DR. GORDON: So those would be groups that we might bring in in different places certainly to talk about provision of programs, perhaps to talk about research, perhaps to talk about public information as well. So we might integrate those different insurance companies and foundations into the different panels.

Great. Thank you.

Julia, were you going to say something as well?

MS. SCOTT: Yes. I think we've pretty much covered in number 3 the provision to health care professionals but I'm still worried about the last part of that and mechanisms for ensuring that this information is readily accessible and understandable to the public.

And I think you started when you brought up the issue of children and how important it is to really start this early in one's life. But I still think we need to kind of think through how we're going to make this understandable to the general public and available

to the general public.

And part of that concern for me is, as we're talking about the town meetings as a way to get additional input, something that Conchita brought up, the fact that we'd be preaching to the converted, kind of, and what we can do to ensure at these meetings around the country that the word gets out so that we'd have the diversity of people in this country represented there so that we're really getting a sense that we're here. Because we're a pretty select group here.

And so I would assume that having these public meetings is a way to make sure we're not in our own little circle and we're hearing other people. So I think that's just a caution to us in how we do those town meetings, the kind of outreach that we do to get people who aren't in the general mix of this whole issue of CAM.

And then how do we make this information understandable. I think it's just been a general problem in our whole health care system. Our public health message is usually one of doom and gloom. People don't want to hear it. So what kind of recommendations can we make that will help get this information out to the people who need to get it.

DR. GORDON: Do you have some thoughts about both of those issues, which I think are really important. How do we get the word out and who would help us figure out how to make it more accessible.

MS. SCOTT: Well, I don't have all the answers, obviously.

DR. GORDON: You don't?

MS. SCOTT: It's something we're always challenged with, and even in our own organizations. But I think there are some of the -- what I know of the women's health groups, such as the National Women's Health Network. It's a consumer group that's very interested in complementary and alternative medicine with their membership. I think they might be able to bring some ideas to the table. And I'm sure each of us might know of some other kind of groups that might help us get at that information.

DR. GORDON: Great.

Tom?

MR. CHAPPELL: Well, I think this is a most important point because the town meeting concept is just right for political issues but we need to be more intentional than that. And the way we can reach the audiences that we need to reach, I would suggest that we consult a market research firm who can help us

understand how to design and reach and be inclusive of these various audiences that Julia and any of us need to think about.

So it's doing more than setting up a listening session. It's really being intentional about getting various audiences there. And I think the market research people doing focus groups do this every day.

DR. GORDON: The other thing is just to ask each of you to send us ideas for organizations, whether in your area or nationally, that you think we should be in contact with for the town meetings and just generally.

What about the second issue, Julia, that you raised, of making the information accessible. Do you have any other thoughts about that or strategies we should pursue?

MS. SCOTT: Well, I think just as we're talking about one of the ways to provide information to the health professionals is looking at their peer journals, I think we need to be looking at what are the ways that information is acceptable to the diversity of groups in the country.

So I think we need to be looking at sort of the lay magazines. And women -- I mean, a lot has been

done to increase the awareness about cancer and breast cancer in particular. I mean, there are certain diseases that have sort of gotten in the market. And so I think it would be helpful to talk to some of those people about how they went about making breast cancer something that all of us know about and talk about and how can we do the same thing with CAM.

And with the recognition that not one vehicle is going to work for everybody, so we have to look at not only the lay magazines but for some cultures and communities it's radio. I mean, breast cancer has been incorporated in HIV and AIDS protection. It's been incorporated into many of the soap operas. That's how you kind of make it be part of general everyday information. Those are campaigns.

DR. GORDON: So bringing in people representative from the mass media who have either done a good job or have not done much of a job to sort of find out why either way, why and how either way.

MS. SCOTT: Right.

DR. GORDON: Great.

Tom.

MR. CHAPPELL: How about programs on nutrition in our school systems. What are we doing and why can't we think of this as a parallel initiative. Can we

learn from government groups or governmental alliances that are helping educate in schools today on nutrition.

DR. GORDON: Great.

Bill.

DR. FAIR: The American Health Foundation, which was started by Ernst Wender has had a very active program in nutrition in the schools and also anti-smoking. Ernst unfortunately is no longer with us so we maybe ought to touch into the American Health Foundation. Dan Nixon now heads that and he's a nutritionist and an oncologist and has the resource of the American Health Foundation behind him. And I know he'd be very happy to talk to the group on that aspect.

DR. GORDON: Okay.

Michele.

MS. CHANG: Just in terms of -- we've come around this topic a couple of times so let me just mention the CDC, of course, is the Public Health agency, so they do go out and initiate programs throughout communities, through community state health departments, schools, et cetera, to do the things like five day and breast cancer and all these other educations.

It just so happens at the CDC, their Division of Nutrition and Chronic Disease has taken on the issue

of CAM. That's where it's housed in CDC now. So it might be advantageous for us to hear not only from CDC as a larger organization but to ask someone from the Division of Nutrition to come and talk specifically about what are their plans.

DR. GORDON: It's a great idea. Terrific. Thank you.

Joe.

DR. FINS: Just since we didn't mention them, I think another option on the professional continuing medical education side are the specialty societies, the American College of Physicians, the American College of Surgeons, pediatricians and everyone else. ACOG. These are all entities that are the major distributors of CME to the practicing physician base and I think we should find out how receptive they would be and how they might envision integrating this into their work.

DR. GORDON: That's a great idea.

DR. ORNISH: And the American College of Cardiology, for example, has planned their first conference on alternative cardiology. That will be next year. And in fact, I was just talking with the organizer of that yesterday. So I know there's interest in those kinds of organizations.

DR. GORDON: Great. Okay.

Let's take another 15 minute break. Research shows that people can sit for about 35 minutes, 40 minutes, and maintain full attention. We're doing better than that. But let's take a break. And I think we may be able to finish the fourth issue on education, professional education before lunch, if we're very fortunate.

(Whereupon, a recess was taken.)

DR. GORDON: Let's begin now on the fourth area.

And just to remind everybody, by lunchtime, please fill out the form that Michele gave each of us about which working groups we'd like to be part of and give that back to her. I think it will make it easier if we can do it by lunchtime.

And then, remember, the public comment will be from 1:00 to 2:00 and then what we'll do from 2:00 until about 3:00-3:30 is go over some of the issues that relate to how the Commission -- some of the practical issues as to how we're going to move ahead, issues of communication among us, et cetera.

*So, let's move from number 3 to number 4, the education and training of health care practitioners in complementary and alternative medicine.

And we've come very close to this and sort of

moved into this territory a bit, but I think what we're talking about here is both the education and training of those people who are in conventional health care programs and those who are part of the other professions that are connected, that are part of the whole CAM enterprise. And also, what kinds of overlap there should be; what should be available to everyone; are there particular standards. And even at least as important, how do we begin to approach these issues of education and training of the professionals.

George.

DR. BERNIER: I think it's fair to say that American medicine has moved fairly slowly in adapting to a changing world. And while some changes have occurred, it's clear that a lot of changes will have to occur, first, to be successful, and for us to be at the cutting edge of what's happening to our patients.

We have undertaken changes that have resulted in change of venue in terms of the educational product with many of our students receiving far more ambulatory training than they ever had. And that was really a response to society's perceived needs.

They have been able to undertake changes like the human genome, end of life issues. And I think to a really remarkable degree, considering the length of

time they've been at it, they have been able to assimilate some of the CAM principles and some of the experiences.

In a lot of medical schools this remains an elective course or courses, but in a number of schools it's becoming part of the standard curriculum and a required course. And I think that's great. And I think that it does mean that there is hope that modern American medicine can adapt and can provide the kind of education which will be most desirable.

I think that if we are able to have the enterprises run in parallel with a lot of overlap that that's probably the best way for this to happen. So I just wanted to make that comment.

DR. GORDON: Say more about what you mean by parallel and overlap here.

DR. BERNIER: I think that the kinds of studies that have been carried out to determine on a research basis whether the various strategies of CAM are successful makes it a lot easier for medical faculty to buy into the idea.

If those studies aren't done, then I think it will be very much a parallel kind of experience. It will not be regarded as mainstream medicine.

DR. GORDON: So you're saying -- or maybe I'm

extrapolating. You're saying that education of faculty about the research will help promote education to the students about the modalities.

DR. BERNIER: Yes. You've said it much better than I. That's it.

DR. GORDON: Thank you. That's an important point.

Others?

DR. FAIR: Now I speak from my doctor aspect. And my feeling is that we don't really need to educate physicians to be CAM practitioners. I think that there is this debate already about whether the physician that takes a quicky course in acupuncture really knows the equivalent of a trained -- someone in traditional Chinese medicine that understand the whole philosophy, and acupuncture is one part of that.

And as we were talking -- Effie yesterday -- is we have to be careful that we don't extract one part which is basically an entirely parallel system to allopathic medicine and say our doctors should be expert in that, and therefore, they'll be holistic doctors.

I think what we have to do is educate physicians to know what's out there and how they can benefit from using these other practitioners. But

also, and it will take some humility on the part of physicians, physicians I think have to recognize that the CAM practitioners are an integral part of the delivery of health care and have to be more open to utilizing these CAM practitioners as part of their healing and make liberal use of referrals to places like the East-West Institute and things like that.

The curriculum of medical schools is jammed packed right now and in my opinion we can't train physicians to be CAM practitioners in the current curriculum without adding a couple of more years to the medical school. So what I would like to see is that we educate physicians to what's out there and also educate them that if they have a particular problem where consultation with maybe a dietician, which is maybe the most commonly used, is appropriate, that that should be done. We don't all have to be expert nutritionists.

In the same way, if we need someone in massage therapy, that should be done. Or in traditional Chinese medicine where you exercise, that we can utilize these other practitioners.

I guess what I'm saying is I don't think we need another medical specialty because, speaking now as a patient, as I said before, there's such a bewildering array of who shall I go to. What I would envision is

the patient going to his or her doctor and that doctor being the one that can orchestrate which modalities would come into play to help the physician achieve healing the patient.

DR. GORDON: Thank you.

Dean.

DR. ORNISH: I'd just like to second what Dr. Fair said, which is that what I'd love to see in medical education is a process of learning and thinking about new ideas, as opposed to compartmentalizing, which the compartmentalization itself is I think the very thing that many alternative approaches are trying to get away from.

In the case of our work, 23 years ago it was very much considered alternative or non-traditional. Now it's become much more mainstream. I mean, it's still complementary to the extent, for example, someone who undergoes bypass surgery, angioplasty, would also benefit from changing diet and lifestyle to keep their bypasses from clogging up. Or somebody might choose diet and lifestyle as an alternative to a bypass or an angioplasty. But if it were compartmentalized as being an alternative intervention, then it would tend to remain separate from the mainstream of medical practice.

And so I'm much more in favor of finding ways of trying to bring the awareness level of physicians to have an approach to the field, to understand how to critically evaluate the evidence of therapeutic efficacy of not only particular fields within alternative medicine like acupuncture but even within a field some approaches are going to be more beneficial or there will be more scientific evidence than others or for some particular conditions or for some types of people.

I remember I went to India in 1979 and I went to an Aurveda school there and I said, I want to learn aurveda. And they laughed at me. I said, because I'll be there for two months. They said, two months, you don't understand. It would be like going to an American medical school and saying you want to learn American medicine in two months. It's almost patronizing to other approaches to think that we can somehow give the Cliff Notes version of them in a medical school and have -- well, you know from your experience in acupuncture.

So I like what Dr. Fair said and I just would like to second it. If we could come up with an approach to integrating it into all aspects of medicine rather than compartmentalizing it, I think we'll

ultimately make it much more mainstream and it will be to the patient's benefit as well.

DR. GORDON: Others?

Joe.

DR. FINS: I agree. I think we really should try to delineate what the general competencies of the non specialists would be. I would think it would be knowledge of what CAM is, indications for referral, the risks and the benefits, the side effects of common modalities and the range of services out there.

And I think that one of the opportunities we have now is that most medical schools are going through tremendous curricula reform and we should encourage them to integrate these things into the problem based learning which is being done in most medical schools now through case vignettes.

And furthermore, we should talk with the AAMC and other entities like the RRC to help foster linkages within academic medical centers with ethics programs, humanities programs, palliative care programs because there's a natural overlap.

Having said that, I do think there may be a role, and maybe Dean and others can talk about this, about fellowship programs at a higher level of training to really give some people who have completed their

Western training an opportunity to engage in translational work, making the kind of connections that you've made a career out of. And I think we might think about whether there should be funding for GME for such work, which I think will really train the leaders of the next generation.

And finally, I think we also have to make money available to medical schools for faculty development and physicians, because I think most medical schools don't have the talent that we have here around this table with some of the leaders in this field, and many medical schools who would want to teach wouldn't have people there to teach. So I think that's another very important area.

DR. GORDON: I just want to add one that I see. In general, I would agree that we're not trying to make Western physicians specialists in CAM modalities. I think there's a very important -- at least one, maybe a couple of very important exceptions.

I think that in order to shift the whole way of doing medicine that all physicians need to become more self aware and more expert in self care. And what I found enormously powerful in teaching these things at Georgetown for 20 years is teaching the medical students, first year especially but throughout, working

with them in small groups, teaching them a variety of techniques that can be integrated into their own lives and into their approach with patients; relaxation, meditation, self awareness, exercise, Yoga, expressive work with drawings and journals.

What I find is, number one, they relax a little. They actually do better in medical school. Very interesting for a paradox because they're not quite as sense about everything. They also develop a more open mind and they have a very powerful personal experience of what they can do for themselves, and so they then relate to their patients in a very different way. They don't think they have all the answers. They begin to see that if they can teach themselves to relax, knowing how tense they are, then they can also teach other people how to do the same.

So I feel that -- and this is what we're hoping at Georgetown to have every medical school go through this kind of small group program. And I see this as fundamental. Education of physicians used to be an education that was personal and spiritual as well as technical and I see this as really important to bring back into medical training.

So experiments for diet, for example. Very fascinating teaching nutrition for a number of years at

Georgetown, seeing what happens with the medical students. But not just on an intellectual level but on a very much experiential level.

DR. FINS: If I could just respond to that.

I think your point is very well taken and I think that the risk of delineating competencies, which I think is important, shouldn't be understood as over dichotomizing the traditional and conventional treatment, whatever those things mean, because the commonality is that whether one is a CAM practitioner or a Western practitioner, you both are healers. And we should encourage the empathy download, whichever direction it goes in.

We have a course at Cornell that promotes self reflective practice with an emphasis on competency at the end of life. And this is a required course. And the students write journals. They observe the care of the dying. And it has a kind of generalized sort of softening and fostering of professional development writ large. So I agree with you completely.

DR. GORDON: Tom.

MR. CHAPPELL: Actually, I have two questions if you bear with me.

First, what do we mean by health care practitioner.

DR. GORDON: Yes. We mean -- I think we mean potentially -- it's a good question. We mean not just people who are practicing conventionally but people who are health care practitioners, whether they're acupuncturists, herbalists, massage therapists or M.D.s or R.N.s or physical therapists.

MR. CHAPPELL: Okay. Fine.

DR. GORDON: Or psychologists.

MR. CHAPPELL: Good. Then my second question really is that right now this is structured to think about how we serve the health care professional or the health care practitioner. But before this is over, it's going to be a center. It's going to be a health care center. Because the consumer is going to indicate the demand for a health care center, not a single professional.

So, I think we need to have some people who have developed wellness centers come in and tell us what they're doing here, because they're delivering. I know this is part of number 2.

DR. GORDON: Right.

MR. CHAPPELL: But it's also connected to the question here of whether a medical school needs to become more diverse in its curriculum or whether we're going to be setting up alternative medical schools.