So I think we'd better --

DR. GORDON: That's an interesting question.

MR. CHAPPELL: Yes. I mean, my image of Western medicine is the sole practitioner with a shingle. I am the doctor. I choose this doctor. It's my primary doctor and so on. But I think the consumer who is driving CAM thinks of the source as the wellness center.

DR. GORDON: I don't know, because there are not so many of them as one might like.

What I see, and our town meetings will tell us a lot more about this. What I see practicing here in Washington, D.C. and what many of my colleagues see is that for the most part people are going here and there and everywhere without much guidance, without much central -- I see you're nodding your head.

MR. CHAPPELL: Yes.

DR. GORDON: And people are calling up all the time saying what should I do, where should I go. If you can't see me, tell me where I should go because I don't have a clue.

MR. CHAPPELL: And the resolution to that in the marketplace would be a health center.

DR. BERNIER: Without walls or with?

MR. CHAPPELL: Both. Without walls on the

internet and with walls in the community.

DR. GORDON: Other comments about this?

Effie and then Bill.

MS. CHOW: To go back to the concept of CAM. Oftentimes we're talking about CAM as if it's another modality. CAM is a way of life. Most of the CAM practices foster a way of life. And so we've got to keep remembering that. And you cannot preach CAM unless you've practiced CAM fully.

Again, you said a walk through walk instead of just talking the walk.

So I think we need to keep that in mind all the time so that we're not talking about teaching the practitioners, and you broached that, to just deal with their clients. It's teaching the practitioners to really be what they're going to practice and learn to touch their clients in talking and look them in the eye and be close to them.

I mean, you sit here like this and your language is like -- okay. I'm helping you. And you know, the energy flows this way and this way but energy flows that way. And just that body language. The doctors, the nurses, everybody should learn something about. And just the touch. It makes so much difference. And oftentimes that's what the patients

need.

I call them clients because they have a right to information and make a decision as to what they want to do, die or live. And you help them die well.

I was mentioning that in helping people die well, suddenly they realize they haven't been living and they suddenly decide they want to live. And that has often happened with our people.

And so therefore, we have to look at education for helping the practitioners to live a better life. Therefore, they can be examples to their patients and then, knowing that, they can advise or references. They don't have to teach the patients but being an example of being less stressful. Therefore, their energy will affect their client better if they're not chewing or something like that, or fiddling or et cetera.

And so then we have to talk about education to the real practitioners a lot more intensive and then qualify what that education might be. And then the informational aspect, what that might be.

So there's different levels, I think, but definitely I want to bring back that vision that CAM is a living essence, not another practice.

DR. GORDON: Are we all on accord on this? I

think we've got it. And I think this is important.

One of the things we want to do is see -- perhaps look at programs, maybe yours, maybe mine, maybe other peoples' where we're actually doing this with health professionals in their educational settings.

MS. CHOW: Just another -- one example. It's really great.

DR. GORDON: Effie, I actually want to move a bit if we can.

MS. CHOW: Can I just give this one?

DR. GORDON: Okay. A quick one.

MS. CHOW: Because this program in Wichita, Kansas, the Center for Improvement of Human Function, they give wellness days. I talk about wellness days. But they are actually giving six wellness days a year and they don't send flower or anything to people if they end up sick or in a hospital. But when they come out of the hospital they send them flower and notes. And it's actually in practice.

DR. GORDON: Bill's next. Then Joe. I don't know if anybody over here --

DR. FAIR: I was glad that Tom asked that question of how to define health care practitioners and your response was quite appropriate, I thought. And

that just underscores the fact that we can't look to the physician to do everything and that we have to treat these other practitioners as partners in health.

And again, to touch on what you said, and I don't know how to do this in the final report, but there's no better way to teach this in medical schools than sounds like what you're doing at Georgetown, is to get the people involved in it. And it's very much akin to the previous discussion about how do we bring things into schools and teach school kids, except this way the kids are a little bit older. They're in medical school.

So I would think there would be a strong -- we should have a strong feeling or a strong commitment to bringing this into medical schools, not with the idea of creating a new specialist but with the idea of teaching medical students how to live better themselves. And, by inference, how they will spread this to their patients.

DR. GORDON: Joe.

DR. FINS: There's one group I don't think I heard, and that was pastoral care people, the chaplains, who I think are critically important providers of spiritual support and healing in the mainstream really. I think we should hear from them.

And also, they've gone through an interesting history over the last 15 or 20 years. There's a College of Chaplains. There's the accreditation processes. There are training programs. They've maintained their separateness but they've integrated.

So maybe we can hear from some of the leaders from the chaplaincy community about how that transformation occurred and it may be instructive to other practitioners.

DR. GORDON: George, were you about to say something?

MR. DEVRIES: NCQA actually has some interesting requirements of programs like the one my company operates where we provide chiropractic, acupuncture, naturopathy, massage therapy benefits for enrollees of health plans. But as part of that, even if the member is able to directly access the CAM provider without a physician referral, we still as an organization have to provide at least notification or a report back to the primary care physician that the member has accessed care and diagnosis and proposed treatment, including like under acupuncture, traditional Chinese herbal supplements that the member might get.

So it's an interesting -- shall we say almost

-- shall we say a process that's already happening. And in terms of someone just talked about the health clinic without walls. It's physicians and CAM providers working together in the interest of treating their patients. And this is a communication process, I guess, that we've already had to institute among CAM providers and physicians regarding treatment plans on patients.

It's been very positive in the context that all of a sudden you see the primary care physicians talking with the acupuncturists and the chiropractor and their provider.

DR. GORDON: So this is a model of teaching to professional students about what can happen, how people can -- in this context?

MR. DEVRIES: I think so. It's in the context too that it's just a real life model of really forcing those practitioners and providers to talk and to work together on particular patients. It's very positive.

DR. GORDON: I want to raise two other issues for everybody's consideration that are related, directly related to this. One is I think certain competencies in CAM, self care, basically, but I think nutrition should be basic to every physician's education. I think it's inexcusable that physicians

don't know more about nutrition than they do.

And you're shaking your heads so I guess we have agreement.

I have a second preference because I've learned how to do it and I don't know that there will be as general agreement. I think every physician should know how to work with is or her hands to do some kind of manipulation. Chinese medicine. Everybody who practices traditional Chinese medicine does manipulation. And I do it. There are plenty of times when I refer to other people because I know what I can do and I know what I can't do. And if I don't, I quickly find out. But to me it seems so much a part of medicine.

And I know this is not necessarily a popular idea in the West but it has been very important to me. And increasingly, physicians want to learn manipulation.

So I raise that as a possibility, at least something to talk about.

The other issue which is a more -- a broader issue is the whole one of what should other practitioners know about conventional medicine. This is very important to me.

I think -- not that the other one isn't --

but I think one of the places we run into trouble in a variety of ways and that CAM practitioners are criticized -- well, you don't know what you're doing. How much do you know about conventional treatment. How can you screen out problems.

And I think there has to be a level of competency among CAM practitioners for understanding what they know and what they don't know. And I think we need to devote some time here to thinking about that.

Dean.

DR. ORNISH: I like the idea because to me the best integrative medicine is when we integrate the best of traditional and non-traditional approaches. And I like what you just said about -- because so often people tend to think of, well, Western trained doctors really don't know about nutrition or they don't know about a variety of different modalities and so they tend to inappropriately use antibiotics or surgery for procedures that perhaps alternative approaches are more beneficial.

But the same problem also exists in the other direction, as you've alluded to. Both from a philosophical standpoint and a practical standpoint, to the extent that education of allopathic physicians can include a greater awareness and appreciation of

alternative approaches and what works and what doesn't work and for whom and under what circumstances and where to refer people to and how to find the best people in the field to refer to and how to credential people and so on.

But also, in the same light that alternative practitioners of one variety or another need to understand that Western medicine really does some things very well and often may not necessarily refer appropriately in that direction as well. So I think we can all learn from each other in that way.

DR. GORDON: Other responses to this?

DR. ORNISH: I would say, by the way, that I'm in complete agreement of including nutrition as part of all physicians' training. When it comes to manipulation or acupuncture or other things that may have great value, I think that it may not necessarily be something that all physicians have the time and interest to be trained in just because of the limitations of resources. But I like the idea of including some basic ideas as part of all physician training.

DR. GORDON: Tom and then Bill.

MR. CHAPPELL: There's a medical school in Maine for osteopathy that's also just going into

complementary and alternative medicines. It seems to me when you bring up the question of hands and so on, they really are an interesting model as I think listened. It's called --

VOICE: The New England College.

MR. CHAPPELL: -- New England College. Thank you. In Biddeford Pool; right? Biddeford Pool, Maine. And Sandra Featherman is the President.

But I do think that they're an interesting model where osteopaths have sort of taken a particular point of view anyway towards medicine and then they're adding to it.

I'm interested in their curriculum in this discussion.

DR. GORDON: And that, of course, raises the issue that we ought to have a greater understanding of various curricula.

MR. CHAPPELL: Yes.

DR. GORDON: Of naturopathy, for example, or traditional Chinese medicine or chiropractic. That if we're going to help make suggestions we need to have some baseline knowledge about what's happening right now.

Bill?

DR. FAIR: Not to beat this issue to death

regarding training physicians to be CAM practitioners, we can't ignore the practical aspect. I think the 8 to 10 minute visit is with us for the foreseeable future. You can't be all things to all people, so physicians are going to have to rely more on other practitioners to deliver these things, like massage and acupuncture and so forth. Unless you think otherwise.

DR. GORDON: I don't have -- personally, I don't have, except in very rare instances, the time or the inclination to do massage, even though I've had some training in it. I think the 8 or 10 minute visit is an abomination except for a kid with a little cut.

This brings us back to the whole issue of services. I think we have to challenge that. And fundamentally, again, this is coming back to Effie's point and the point that many of us have made, is that the whole vision of CAM is not of an 8 to 10 minute visit. It's a vision of some kind of what I call healing partnership with people. And I think that's part of our world view. And even though it's a major change, has to happen.

For that to happen, I think that we need to come down on the -- I think we shouldn't accept that particular status quo.

DR. FAIR: I'm just saying that the --

DR. GORDON: That doesn't mean we shouldn't refer to massage therapists or acupuncturists or other folks.

DR. FAIR: Sure.

DR. GORDON: I just think that in order for us to do a decent referral, how are you going to do that in 8 to 10 -- are you going understand who that person is and who they would best work with and what's most appropriate for them.

DR. FAIR: Well, certainly, you're preaching to the converted here.

DR. GORDON: I know.

DR. FAIR: Maybe George could give us more information about how the insurance company views that because what I hear from physicians in practice is that's a way of life and not really likely to change very much.

DR. GORDON: And when think about it, Dean was telling me last night something I hadn't realized. That when the President or some of these high officials go for a physical, it's like an eight hour position and different specialists have their turns. And maybe we ought to start thinking along those line.

Again, we don't need one person to do all things. That there would be a physician who may sit as

the captain of the ship, if you will. Somebody has to coordinate it. But then al of these other practitioners get in their part, too.

So in toto, it takes a lot more than eight or 10 minutes but maybe the captain of the ship would have a short period of time.

DR. ORNISH: But just to respond to what Bill said, as you know, many of the alternative approaches have as their approach to treat the underlying cause of the problem. Now the cause may be identified in different ways in different systems of thought but still the idea is to treat the cause rather than to like literally or figuratively bypass it.

In the case of health care costs, one approach has been, as you alluded to, to shorten hospital stays, shift outpatient surgery, more doctors to see more and more patients in less and less time, in eight minutes to see a new patient. And it's profoundly frustrating for both doctors and patients which I think is part of the reason why so many people have been voting with their feet and paying out of pocket for these services because one of the things that most alternative practitioners have in common is that they spend time with you. They listen to you. They often touch you. They do the things that make

people feel connected, which is why people are even willing to pay out of pocket for it.

And I think that if we can encourage approaches that look at -- I mean, for example, we found that by spending much more time with people, spending a year with people, it actually saved an average of almost $30,000 a patient as an alternative to a bypass as one example that spending more time with people actually save money. And I would encourage testimony from people who have similar experiences in that area.

DR. GORDON: I think that's very important.

I going to come to you in a second, Joe.

One of the things that my experience has been is that by spending more time with people, I get almost no phone calls in the middle of the night. I get almost -- it's a whole different situation that the more connected you are with people the more they learn to take care of themselves. And that's a very interesting, very interesting paradox. And that our work, I think, is really about what's the model for the physician.

The other thing that you raised, both of you raised, is that it's enormously frustrating for physicians.

DR. ORNISH: Well, that's what I was going to say. It's profoundly unsatisfying both for physicians and for patients. And if we can help emphasize that rather than doing this as threatening to physicians, which is often how it's perceived, that it's a profoundly satisfying way to practice medicine.

You reduce your malpractice costs because people are much less likely to sue you if they feel cared for. And it's a whole lot more fun for everyone involved. And I think that message really hasn't gotten out as much as it could.

DR. GORDON: Joe.

DR. FINS: On that point and the earlier point about education, I think to go back to number 1 about the research gaps, I really think we need to do outcomes of research that looks at cost benefit analysis and real efficacy. I mean, if someone gets acupuncture, if someone gets massage and their back pain keeps them at work, going to work instead of being at home, what is the long-term consequences economically of these interventions, which may, if you look at it microscopically, is a longer visit. It's not the eight minute visit. It's the 45 minute session.

What does that mean for disability and

wellness and productivity. And I think we should -- when we think about the research mandate we should include those kinds of outcomes.

On the education issue that we were just talking about, it would seem to me that it would be good to have some RFPs from some funding entity about substantive and process issues in complementary and alternative medicine. You know, strategies for doing this.

I think we know more and more about what CAM is but we don't know a lot about how to teach it. And it seems to be it's a very robust field, the strategy of bringing into the medical school and nursing and other curricula. And I think that might be a nice RFP for either the National Center or HHS or something.

MR. GROFT: That actually exists. I believe there is an RFP or an RFA out on the streets right now that deals with developing curricula.

DR. FINS: Okay. Great.

MR. GROFT: And several of these things I know are available through NIH grant programs already. So I believe there is something on the street at the present time.

And again, I think Richard Nahin, who's in charge of the extramural program there with Steve

Strauss, can help us with that, too.

DR. GORDON: Effie.

MS. CHOW: I hope we're keeping the vision that CAM is part of a whole team. It's not an alternative to Western medicine. And that still the primary -- and as much as -- you know, I'm a nurse myself and have great respect for the medical system. It's a misuse of the medical system that is the problem. It's not the medical system.

And I hope that the vision again is to see the alternative, what is called complementary and alternative medicine. And I would like another word rather than that. It is teamwork and not one star. And then the medical doctor, in due respect to all of you here. And then CAM is like added on and it's always the doctor that has to be the master of the ship.

For example, I myself, when I have people and they haven't been to a doctor for a long time, I refer them to a doctor. But I'm the master of the ship and the doctor gives me a report as to what's happening. And the client needs to inform all the practitioners of what they're taking.

Because, like you said, Jim, they're shopping around and we need to devise a method to help them to

stop shopping around. Because even when something is good for them, they still think there's another miracle thing out there and they don't deal with the treatment deeply enough, so that they don't get the benefits.

And they also come to see the complementary and alternative medicine when it's a dead end rather than early referral. And so, for example, how can we devise education and practice code that perhaps going to early referral to CAM can prevent some of the seriousness, which Dean is doing, as one model. And that can be promoted on a larger scale.

So I'd like to turn it to the team, not the physician, and then the CAM rotating around that.

DR. GORDON: So we can look at a variety of different kinds of models.

MS. CHOW: Yes. And so that your point about education the CAM practitioners that they need to work with the medical model as well and be informed. And so when to refer and when to do so appropriately.

DR. GORDON: There's a few more minutes.

MR. ROLIN: Buford Rolin here. I Just wanted to make a comment. In the Indian Health Service we have that model right now. The only facet that we're missing is the CAM and that's where we're really working now within the system to make that available.

I know with a couple of our hospitals in the Navaho area, they're already set up and have that established. But how do we incorporate that. We like to think that our model is one stop shopping and the hospitals or clinics that we operate. But that's the one facet that we've got to be able to make conclusive in that process and that's what we're working on there.

But we do have a model in that aspect. I just wanted to share that.

DR. GORDON: In terms of education, any education of health professionals, we're agreed that we're going to address education of all health professionals? And we need to learn more about some of the systems. We need to talk about the spirit of the practice as well as the individual practices. That nobody is going to do everything but that there has to be a kind of informed understanding of all the different professionals about other professions. And there has to be a sense of teamwork. And students of all kinds have to be exposed to the best thinking.

And think there's still too much polarization, and not just on the part of conventional medicine but also on the part of some who are alternative practitioners. And I think we need to sort of see what kinds of models of collaboration and

collaborative teaching there can be.

Anything else that we've omitted here?

(No response.)

Great. So we will break for lunch. We'll be back here at 1:00. We'll have lunch. We'll come back at 1:00.

VOICE: Jerry, would you want to check to see if the lunch has arrived?

DR. GORDON: How could the lunch no be here?

So we're going to break for lunch in any case. We'll be back at 1:00 for public comment.

How many people do we have, Michele?

MS. CHANG: Seven people.

DR. GORDON: We have seven people for public comment. We'll do that between -- we'll finish with that by 2:00. Then we'll finish our discussions here by about 3:00 and we'll be planning for the next meetings as well.

MR. ROLIN: Jim, could I just make a comment? I'm going to have to leave after lunch. I cannot be here this afternoon. But I just want to say to all of you that indeed it's a pleasure for me to be part of this Commission and I'm looking forward to bringing our perspective and from my community, making it a part of this.

And I know Egaly as well. When we were talking about organizations a bit ago and how we can have some input, I think of our American Indiana Physicians Association and other organizations that we have that certainly we can have input and bring that perspective to this process.

And so I'm really honored and certainly appreciate the President for his consideration in appointing me to this Commission and I look forward to working with you all.

DR. GORDON: Great. Thanks for being with us.

(Pause.)

We don't have lunch?

Can we move on?

MR. GROFT: That's what I was thinking.

DR. GORDON: Okay. Everybody up for that for another 10 or 15 minutes of discussion?

Okay.

MR. GROFT: And my apologies. I don't know where the food is but I gather it's between here and Arlington. As soon as it arrives we'll break immediately.

DR. GORDON: Okay.

MR. GROFT: We've talked about a number of different activities that we'd like the Commission or

that you would like us to do and that we're willing to work with you in implementing. And so if you could jump ahead a little bit to number 7, other activities of the Commission, just to give you some ideas of what we were thinking about doing to make your activities a little bit better known to the public and a little bit more visible to everyone.

We do want to produce an interactive website in the sense that we'll receive communication from the public about the activities of the Commission, including the issues and questions that we develop, especially as we start to go out into these town meetings. We would like to present the same questions on the internet and let people respond to us.

I think as we do this, we want to let you know that we will not respond to those inquiries. We will simply receive inquiries. There's far too much work and almost impossible to try to respond to perhaps tens of thousands of responses.

DR. GORDON: Steve, clarify what you mean.

MR. GROFT: The website, the internet site. We would put up the agendas. We would put up the questions that we're addressing, the issues that we're addressing to receive input from the world.

DR. GORDON: And we'll be putting up summaries

or minutes of these meetings?

MR. GROFT: Summaries of what goes on here. The minutes from the meetings, as we develop the issues.

And say as we start to prepare sections of the report, the Commission wants us to put up a section of the report to get comments on, we would do it. We would put it out there and let people comment, bring those comments back to you to let you know what people are saying about what our activities are and what our conclusions are and what we should change.

DR. GORDON: But what did you say we could not respond to?

MR. GROFT: All the responses. We cannot respond to the responses.

DR. GORDON: Respond personally to every question that's raised.

MR. GROFT: If 10,000 people send us a response to the issues or 5,000 people, we cannot respond to those. We have to be willing to receive them and not respond. It's impossible. And I don't mean to sound like we don't care, but we will take them and we will synthesize them, but to try to provide an individualized response -- we may be able to send back a short thank you, that we appreciate your comments and

we'll continue to keep you informed and keep checking our website for information, just to let them know that we are paying attention but we can't answer.

DR. BERNIER: But you will be putting all this on the website?

MR. GROFT: Yes. All this will be on the website and available.

I've run a website for the Office of Rare Diseases and it's quite a task trying to keep up with inquiries without a full blown information center itself taking care of the inquiries that are coming in or a much larger staff that what we want to bring in.

We don't want to bring in people to respond to inquiries from the public because that really in NCCAM's -- what will happen, people will start asking us questions about specific interventions and treatments and we don't want that to occur. We want to continue to focus on the issues and the questions that you have the responsibility to answer and put together.

MR. CHAPPELL: Can we post commonly asked questions with responses to those commonly asked questions?

MR. GROFT: If we see a pattern developing of questions, we could put up frequently asked questions and a response. Again, we may not want to do that. We

don't want to short circuit questions by providing answers. But I think as is typical with a web site, it evolves. And I think before we would do things, we would have a beta site that we would tell all of you to go look at first or ask you to look at and see if this is what you want to do.

And even before we go public with everything, as we make changes, major changes, you first would have the opportunity to look at what we're putting up and get a quick concurrence back from the Commission members that indeed this is okay to put up.

DR. GORDON: But Tom, I'm wondering -- and Steve -- if what you're looking for, we could certainly have an information sheet about the Commission, what the Commission is doing, who the members are, the kinds of issues that we're focusing on that we could send to everybody.

MR. GROFT: That would be the first part that we would identify the Commission and put in all the Executive Order and everything else that goes with the charter and what have you. That would just be the easy -- they're the easy things to do. It's then identifying the issues, getting responses and things like that.

MR. CHAPPELL: Then with regard to our

listening or reading, are we going to read and listen to the responses?

MR. GROFT: Are you?

MR. CHAPPELL: We. You.

MR. GROFT: We will. Yes.

MR. CHAPPELL: Okay.

MR. GROFT: Oh, yes. The idea being that we would collect them ourselves and incorporate the comments and suggestions into the documents that we're preparing as we move along. We're not just going to throw them away. We will collect and we will save them.

MR. CHAPPELL: So they'll find their way into this room.

MR. GROFT: Into the report somehow or other.

DR. GORDON: Steve, you'll be able to bring -- if there are issues that are raised frequently, you'll bring them here to the meetings?

MR. GROFT: Oh, definitely so. Whatever comes up we will keep you informed. If new issues are brought up, we will prepare summaries of what is presented to us from the website to that you're not kept in the dark as far as what is the public really saying.

So we would synthesize this into some type of

a workable document.

MR. CHAPPELL: But it's not truly an interactive website then?

MR. GROFT: Not totally. It's just that they can send us messages. We can send a message back. We also can send back directly a summary of the minutes to everybody who sends us an inquiry. From each meeting, we then can -- as soon as the minutes are completed, we can send them a copy of those minutes, mass distribution, so we don't have to it individually. And that's something we'd be building up to. People who respond and send us questions or send us responses, we would create a master list, a list serve, that they would then be recipients of everything that goes out.

I think to keep them informed, I think there would be the feeling that we are contributing something back to them for the time that they've taken to respond to our needs. I think if we could do that, that would be helpful.

Any other suggestions? We're really open. I think as we go along and start this, it is something in evolution that we'll want you to look at and tell us what we should do and how it should be altered.

MS. CHOW: To prevent having to answer a lot, perhaps in the notification saying that the questions

will be taken into account, too, so you don't have to answer those. And if there's a lot of questions, then you might put that question back out to the public and get some --

MR. GROFT: Definitely. There are things that we can do. You will be kept informed as we go along. And as I said, the beta site gives you the opportunity to look at everything before it goes out.

DR. ORNISH: Since we're still waiting for --

DR. GORDON: The food is here, so --

DR. ORNISH: Oh, lunch is here?

DR. GORDON: Yes. But we'll just finish this up.

DR. ORNISH: I was just wondering if we were going to talk at all about public meetings or is that something you want to wait until later?

DR. GORDON: Why don't we do that after the public comment. We'll talk about that.

MR. GROFT: If you have your calendars or anything, maybe we could look at that after lunch then or later in the afternoon.

DR. ORNISH: One of the things that Secretary Shalala said yesterday was how important it is to try to pick meeting times when virtually everybody can be there. And since some people are leaving even before

lunch, maybe we could just take a moment and get our calendars together.

MS. CHANG: I have Buford's already.

DR. GORDON: We have Buford's?

MS. CHANG: Yes. And Charlotte. I didn't get hers.

DR. GORDON: I've got her.

So we have the two people who are leaving. I'm wondering, since we want to start the public session at 1:00 and we don't want to hurry through our lunch -- you'll be here at 2:00?

DR. ORNISH: I may not be and I know some other people definitely won't be. So I just thought -- because it's just so hard to play phone tag with everybody.

MR. GROFT: Let's throw out the next possible date of the whole Commission.

DR. ORNISH: I think it would just take three minutes.

MR. GROFT: We were thinking of around October 4th, 5th or 6th.

DR. ORNISH: October 6 would be a good day for me.

MR. GROFT: Would be?

DR. GORDON: Well, it's going to be at least

two days.

MR. GROFT: We'd like to have two days.

DR. GORDON: And perhaps two and half days.

VOICE: What days of the week are they?

MS. CHOW: How about the next week?

MR. GROFT: Wednesday, October 4th; Thursday, the 5th, and Friday, the 6th.

DR. ORNISH: I could do -- the 5th and 6th work for me.

MS. CHOW: How about the following week? The 11th and 12th?

DR. GORDON: 5 and 6 is fine.

MR. GROFT: Does that look okay?

(Whereupon, a discussion was held of future meeting dates.)

DR. GORDON: Anybody else who has to leave, and obviously we want everybody to be here for public comment and for the small remainder of the afternoon time. If you have to leave, please make sure you've filled out your form about which committee, which interest group.

MR. GROFT: We are looking at October 5th and 6th as the next date then.

VOICE: Here in D.C.?

MR. GROFT: Here in D.C. in all likelihood.

Now there may be something in between, a couple of town hall meetings that some of you may want to attend if it's in your local area.

DR. GORDON: What I'd like to do though is to adjourn because people are already leaving for lunch. So if we can adjourn for lunch. We'll come back at 1:00 to do public comment and then we'll work out -- we'll talk about town hall meetings here and we'll also talk about them individually with people as we develop time.

(Whereupon, the luncheon recess was taken at 12:07 p.m.)

*AFTERNOON SESSION

DR. GORDON: We're going to have public comment and I'll ask each of you who's going to be speaking to us to stay within these guidelines.

No more than five minutes for whatever you have to say. And then if Commission members, if you have questions, please feel free to -- and you want clarification or you'd like to ask questions, please feel free to do so. We'll have a few minutes after each talk to do that.

And when you begin, introduce yourself and say who you are and where you come from, and just begin.

MS. TRACHTENBERG. Hi. My name is Duchy Bracht Trachtenberg. I'm a clinical social worker and I actually work and live in Maryland right outside D.C.

I'm here today actually to speak on behalf of the American Public Health Association's special interest group on alternative and complementary health practices.

The outcomes from public health initiatives depend on many of the same independent variables that affect standard clinical practice, including compliance and interactions. In recent years, however, these factors have changed remarkably. The public's

increasing use of alternative and complementary therapies has introduced new issues that affect most clinical events.

Alternative and complementary health practices are in effect the definition of exclusion, referring to those treatments having alternative origins outside of the conventional medical system. It can include everything from trained, licensed and regulated naturopathic physicians to patient self treatment, dietary supplements and mail order providers on the internet.

The potential for significant differences in quality and safety of care are obvious.

Our ability to take advantage of the benefits and avoid the risks of ACHP therapies in public health depends, in my opinion, on consideration of the following principles.

ACHP therapies are here to stay. Ignoring them only forces us to make decisions without all of the information.

ACHP therapies present both benefits and risks not unlike conventional therapies. While natural therapies have many well documented uses and tend to be less toxic and more accessible, they also generate significant morbidity and mortality when used

incorrectly. The same considerations, including compliance, drug-nutrient interactions and assurance of proper administration apply here as well.

ACHP is not a simple subset of conventional medicine. Legitimate providers often require unique training to the level of conventional medical physicians in order to safely and effectively apply these therapies. It may be a mistake to assume that the conventional medical model can inherently evaluate or apply alternative therapies.

The effective combination of conventional and ACHP approaches has the potential to improve public health outcomes and reduce cost. The addition of alternative strategies can affect many current public health initiatives in many ways, including improved compliance outcomes and cost.

Participation of all types of licensed health professionals who include alternative therapies in their practices should be included in any public deliberations. In particular, chiropractors, naturopathic doctors and licensed acupuncturists should all be included in the deliberations of this Commission, not just M.D.s. In any of the states that have recognized another type of health professional with licensure or certification, then that type of

professional should be represented here.

And finally, coordination of federal initiatives needs to begin so that outcomes can be measured accurately and efforts are maximized rather than duplicated. And I'd ask you actually to refer to a proposal which was actually created within our special interest group at APHA. It's entitled "A Modest Proposal," and I've given it to you so that you can review it.

Initiatives, taskforces and programs dealing with alternative therapies are sprouting up from one end of the Department of Health and Human Services to the other, and many departments, including the Veterans Administration, the Center for Substance Abuse Treatment, HRSA, they've all conducted ACHP activities. There is a need for a single focal point within the government to coordinate these activities, including but not limited to research.

The NIH should be allowed to focus solely on research and other ACHP issues should be coordinated at the department level.

In conclusion, I suggest that the best public health outcomes will result from a credible and meaningful collaboration of common sense public health wisdom and competent therapies. This collaboration, to

be effective, must include well trained and knowledgeable providers and managers from both areas. It must also include careful consideration of all independent variables, including patient self treatment, subject reliance on untrained providers, and the potential for these actions to undermine public health objectives.

Simply put, our culture has changed and the American Public Health Association's special interest group on alternative therapies has started the process of accounting for the new benefits and risks that come with the popularity of alternative therapies.

Our group has several hundred members currently, including NDs and licensed acupuncturists and we are continuing to bring additional types of health professionals into APHA who often have their first contact with organized public health within our group.

We recognize an affinity between holistic practitioners and public health which, by its nature, has always taken a holistic approach. And actually, what I would like to also add at the very end is I would encourage this Commission to actually make contact with both Dr. Joe Pizzorno, who is our chair, the recently retired president of Bastyr University.

And I would also encourage you to speak to Dr. Alan Trachtenberg, who is our founding chair, who obviously is known by some of you here, who was the planning chair for the acupuncture consensus panel at NIH and is currently with the Office of Pharmacologic and Alternative Therapies at CSAP.

Thank you.

DR. GORDON: Thank you very much.

Do we have any questions or comments from the Commission members?

(No response.)

Okay. I think we're all concerned about public health aspects and we welcome input, as well as your modest proposal for coordination at the federal level, which we will be considering.

Thank you.

Next is Sandra McLanahan.

DR. McLANAHAN: I'm Doctor Sandra McLanahan and I think this is an amazing experience to be here to watch this. It's kind of like a dream team out here. And it's an auspicious time, sort of a quantum leap for our culture, suitable to the new millennium.

I think it's really a chance for us to start new with medicine and a broader vision of medicine.

I particularly want to thank Jim Gordon for

starting on the note that he has and I've watched him at the Chantilly meeting do such a great job of bringing together people from diverse backgrounds and creating dialogue. It's so useful.

I love to quote Winston Churchill. He said, I trust America to do the right thing after having exhausted all other options.

So I think we're at that moment.

As Effie was saying earlier, we don't have a health care system. We have an illness care system. And we don't have medical school, we have drugs and surgery school. So we need to make some fundamental shifts. And I think you're all in a position to help create that.

It's just us. It's us. And we look out the window and we see our people suffering and ourselves. And so what are the steps. And so here's my sort of wish list and I'll kind of go through it quickly.

I worked with Dr. Denoresh from the beginning fo that research as the Director of Stress Management Training. I worked with Michael Lerner, to help set up Commonweal. And we went around the world to look at alternative complementary care for cancer.

Then I worked with Mehmet Oz to use pre- and post-surgery alternative CAM interventions pre- and

post-surgery and now I'm working on a couple of projects. I work with Dannien Brinkley for Compassion in Action, which is end of life care trying to get CAM into end of life care and hospice and into veterans hospitals, which are our worst hospitals and should be much better than they are.

And also I work with about 14 different practitioners in kind of a model. When we're talking about different models, it's kind of a Mandala or wheel model where each practitioner has important comprehensive contributions to the whole picture, a sort of comprehensive evaluation.

And what we've done in the past, and I've worked in this fashion for 30 years, is take a patient, have them seen by all the different types of modalities, medicine, chiropractic, osteopathy, acupuncture, psychiatry, nutrition, and then prioritize what's most important and help the patients themselves choose a pathway through alternative medicine. So I like the wheel model there.

I think if you go into any hospital and try to figure out why people get sick, it's cigarettes, alcohol, bad diet, lack of exercise and stress. And these are the things that I hope you all will focus on because we've gotten switched in our emphasis in

medicine to the interventions, the drugs and the surgery, rather than to the root causes.

And if we go back to the roots, let's look at what alternative medicine and CAM in general has to offer in terms of the roots of what's making people sick; cigarettes, alcohol, bad diet, lack of exercise and stress. Those five areas.

Part of the reason that NIH can't do it all is because with their $15 billion, which you'd think you could buy some health with $15 billion every year or more, the test tube molecular model has sort of gone about as far as we can go. The genetic way of looking will provide some more information, but we need to again see what's making people sick. And just knowing, as we know all the genome -- we just saw yesterday in the Washington Post the environmental contribution of illness, the diet, the choices of lifestyle are really 95 percent of the problem.

So how can we shift our medical care system to look at those roots.

And just to say that society's perceived needs -- I love that statement. Somebody made that this morning. What are our perceived needs in terms of medicine and health. We have 200,000 documented deaths a year from medicines and only 40 documented deaths a

year from herbs. So unfortunately the media, as soon as there is one herbal problem splashes it all over the place, and then the general public doesn't know what to do and how to sift through it.

It's hard enough for us as medical people to sift through what's good and what's not good. The general public, who doesn't know whether it's a good study or not or whether the media is presenting it way before the information is appropriate and so forth, has a much harder time.

So I'd like to see these emphasis of the Commission, and I'll just finish up.

Outcomes research, pre- and post-surgery is a great way to study alternatives and CAM in general. The problem, say, for example, with chamomile. It's a wonderful remedy for stomach problems. But nobody can patent it so who's going to fund the research.

Athletes are using magnets all over the place. Do we really know the full range of what kind of long-term effects and how much to use. When I'm sick, how much Echinacea to take. These kinds of questions haven't been answered yet as far as I know, and they're good questions.

And maybe you could commission a report like the Chantilly Report that answers the kinds of

questions we've been talking about the last couple of days. It feels like the general public is the Queen Elizabeth II. It's already sailed. The majority of people are using alternatives and here we are like this little tugboat waving behind trying to figure out which way to go.

We have a purpose, however, which is to provide some kind of summary. And in that summary, I'd like to see the following.

A book list. It could be a simple book list of the things that we think people could get started with. You could put that book list on the website. That wouldn't take too much time and I think it would be very helpful. The books I think of -- Jim Gordon's, would be really helpful, and Dean's. Michael Lerner's books, Dannien Brinkley's book, "Saved by the Light."

There's a book, "Eye Care Revolution" on alternatives for reversing cataracts without surgery. "Healing From The Heart," which is Mahmud Oz's book on using alternatives in a surgical setting. And then "Integrative Cardiac Care" is a new book for all cardiologists on integrative cardiac care by Dr. LaMole.

I'd like to see our meetings have stretch breaks and let's have complementary and alternative

medicine right here as we meet. Let's look at the food. Let's look at the air. Let's look at plants and nature.

In summary, my best alternatives that I've seen in 30 years of doing this work, massage and body work, hypnosis, group support, acupuncture, Yoga, herbs, music, aroma therapy, color, love, prayer and spirituality.

This kind of thing could be introduced into our schools. We could have a lunch program of stress management, a lunch program like they have mandated from the government, a lunch program so our children eat well. How about a lunch program so they reduce stress well. Sort of a stress immunization program. And for computer workers, especially for Post Office workers.

We could have warning labels on foods just like we have warning labels on cigarettes. They could be labeled something like "this Coke has seven teaspoons of sugar, which increases your risk of -- seven teaspoons. And Mountain Dew has nine teaspoons of sugar in it. -- increases your risk of diabetes, heart disease, toxemia of pregnancy and white sugar and white flour could have little labels on them. And when they appear on television afterwards -- I don't know if

the drug companies know what they're really doing with all these advertisements that have at the end of the advertisement all the things -- diarrhea, bleeding, headaches, migraines -- what they're really doing to themselves. But we still have patients asking for it despite all the lists of side effects.

So what about having a mandate to have foods be labeled. We have foods that are labeled for their positive effects now. Wheaties helps prevent cancer of the colon and so forth. We could have foods labeled for the negatives.

I was in a book store where a woman came up to the weight loss books and the Atkins books were there. And she said -- I said to her, that's not really a very safe diet. And she said, but a doctor recommended it.

So in conclusion, I think you have a chance here to really help people sort out what works and what doesn't work.

And I thank you very much.

DR. GORDON: Thank you, Sandy.

Questions?

Bill.

DR. FAIR: Thank you, Sandy.

I'd also like to start with one of my

favorite quotes from Churchill. "Action based on perfection equals paralysis." I hope that doesn't characterize this Committee.

DR. McLANAHAN: Well said by a surgeon.

DR. FAIR: We won't get everything perfect.

But I think you made an important point that we haven't discussed I think so far, and that is that the CAM therapies hold with it not only the promise of helping the disease but helping the prevention.

DR. McLANAHAN: Yes.

DR. FAIR: If you get surgery or radiation, you're not really preventing something. You're treating something. But it doesn't help --

DR. McLANAHAN: Exactly. About 95 percent of our health care budget goes toward treatment. Only five percent toward prevention. It really needs to be the reverse.

DR. FAIR: Oh, yes.

DR. McLANAHAN: We'd all benefit from that type of change.

DR. FAIR: And what's the other figure that's often stated. Eighty percent of all the health care costs that the average individual incurs in his or her lifetime occur in the last six months of life.

DR. McLANAHAN: Exactly.

DR. FAIR: Which is an astonishing figure.

But my question to you was were you suggesting or were you recommending that it's time for another Chantilly Report? Something like that?

DR. McLANAHAN: I would say an updated -- well, you could commission an updated Chantilly Report. That would be one thing you could do instead of doing it yourself. But you could also in your report take the Chantilly Report one step further, which is to look at the social origin of disease.

We are social creatures. The number one risk factor for illness is social isolation and so forth.

You could look at love and survival and all these complex factors and come out with a policy which would actually help people be more healthy.

For example, what Jim Gordon's doing in Kosovo to help those people recover is a remarkable model. We could present that type of model for our entire country in various ways: in schools, in hospitals, in workplaces, work sites and so forth. That could be our health policy. And I think we'd all benefit.

DR. GORDON: Great. Thank you, Sandy.

Any other questions or comments?

(No response.)

Okay. Great.

Sandy has been working in this venue for some time doing wonderful work herself.

Thank you.

Next is Tony Martinez.

MR. MARTINEZ: I'm actually under the stress of trying to see if I can catch a 2:00 flight out of National, so I'm going to be very to the point.

I want you to know that I'm really honored to make these brief remarks and as you all begin this very important work.

I appear before you in my capacity as a citizen, although some of you know me through my professional work.

I'm an attorney by training and I've always been a tireless advocate for complementary and alternative medicine and I've devoted myself to helping integrate CAM into our health care system.

As some of you know, many individuals, including myself, advocated and worked very hard for the creation of this Commission, and this Commission is really a tribute to the leadership of Senator Tom Harkin and the others in Congress who gave life to this Commission.

You all have an extraordinary opportunity

before you, and I urge you to consider the potential impact of your participation and the Commission report that you will create will have on our health care system and use it to help transform our health care system to be a real true model of health care.

Literally millions of people are counting on you to draw up a plan that will help integrate CAM as a full participant in the American health care system.

So with this in mind, I wanted to give you some suggestions on the context of what I believe you ought to include in your report. And that is essentially a legislative concept and policy objective draft that essentially the domestic policy advisor to the President of the United States, the Secretary of Health and Human Services and the Congressional leadership could easily take and adapt and transform your recommendations into appropriate executive orders, federal regulations and legislation to implement the changes and advice you will recommend.

So I make the following suggestions for your consideration as you begin.

Number one. Invite and solicit testimony from the trade and professional associations representing the providers of CAM services and health care products.

Two. Invite and solicit testimony from key leaders and persons in the CAM field. There are many individuals who can give this Commission much guidance and knowledge.

Three. Request the attendance and testimony of representatives from the appropriate and respective agencies who would be impacted by your report. Your recommendations will generate changes to various statutes and regulations and there is unfortunately a history of missed opportunities and abuses with respect to complementary and alternative medicine by some federal agencies.

While it is not your charge to act as an investigatory body, the experience of CAM by patients, professionals and business people with respect to certain federal agencies should be brought to light so you can better advise both the executive and legislative branches.

Four. Let us remember that CAM is not just a federal health care issue. It is a state issue in every state of the Union. Please be sure to request the attendance of respective governors, health policy advisors, state health commissioners, as you travel around the country.

And the last recommendation. CAM is also a

federal health issue and you should request that the respective congressional committee chairs with jurisdiction over health care funding and policy detail staff to participate and observe this Commission's proceedings. And I recommend that the executive director and the Commissioners personally visit with the various members of Congress responsible for health care policy and inform them of your activities and solicit their input and support where it's appropriate.

And please know that your report will be supported by the grassroots public because they've been waiting for something like this.

Thank you for your time. I look forward to contributing and working for the success of this very auspicious Commission.

Thank you.

DR. GORDON: Thank you.

Tony, it's actually so wonderful to hear all of you and to look over this list because it's like a Who's Who of people who have helped to move this whole movement ahead. And Tony, you've been fabulous for may years.

So thank you, and thank you for your comments.

Do you have a minute or two before you go?

MR. MARTINEZ: I have a minute. They have a taxi waiting for me.

DR. GORDON: I had a specific question about the kinds of people who are having issues with regulatory agencies that you think might be most useful for us to hear.

MR. MARTINEZ: I think, for example, you can look at it from different aspects. From a patient standpoint, you can see the travails. I mean, most people do not realize from a legal standpoint that Americans do not have medical freedom of choice.

The regulations that are imposed by the Food and Drug Administration, they only impact people at a very critical time of their lives when they're facing terminal or very serious illnesses, and then they've got to scramble.

I speak from personal experience. When my father was diagnosed with lung cancer, I had to drive him to Ottawa General Hospital in Canada to get a therapy that was not available here and we didn't have the time to go through the rigamarole with all the bureaucracy. So I think it's important that you have some patient talk about that.

There's a very famous case, a little boy who's trying to get the anti-neoplasma treatment,

little Thomas Navarro. These people really feel and experience the harsh reality. That there isn't freedom of choice here in this respect.

I think you need to also speak to some of the businesses. I can say legally some of the agencies have very heavy-handed tactics. I'm all for good enforcement. And if you're not following the rules, like for example, I have extensive background in dietary supplements and I know if you're not producing a high quality product or you're mislabeling a product, I hope the FDA takes your product off the market, takes swift action against you. But in this whole area with claim, we need to start looking at and speaking to the experience.

This issue about non-patentability of natural products. There's legislation out there that begins to address this and there are people who really could give their expertise. So hopefully you'll have some business people as well as the patient perspective.

DR. GORDON: One thing that I'd like to ask for from you is -- two issues jump out at me. The first is what should we expect from manufacturers and how can we create a situation so people are actually getting what they're supposed to be getting. So I'd like your help in that.

And I'd also like your help in -- and this is something we haven't touched on so I'm particularly glad that you're bringing it up -- in how do we ask the right questions to create an atmosphere where we can make recommendations about freedom of choice. Who do we ask the questions of, what kinds of questions, what are the most important issues. If you could help us formulate some of that.

MR. MARTINEZ: There are three areas that you can look at in this regard. One is to start looking at, thinking about giving Congress some consideration as to a model of how to incentivize clinical research and research and development of these natural products that are so difficult to patent. That's one.

Second, I think in your evaluation of the health care system of CAM, you have to look at the tax code. There are some tax problems in the fact that people -- insurance companies, there's no incentive for insurance companies or employers to provide benefits because of the way the tax code is written. That needs to be addressed so that there could be full coverage and incentives for benefits.

And then third, you have to look at an overall model of how to interface both the federal and the states. So how the federal government can create

the kind of federal policy that would incentivize and promote the states to move forward and start integrating CAM in their respective states.

DR. GORDON: Great. I hope we'll be able to call on you.

MR. MARTINEZ: Absolutely. You can count on it.

DR. GORDON: Great.

Tom.

MR. CHAPPELL: I'm not sure I heard the answer to this question about how we would bring about efficacy in terms of promising a product and what's actually delivered.

MR. MARTINEZ: Well, the way that the law is reflected on that is that there is federal regulations for good manufacturing practices and there's got to be an adherence to those GMPs by manufacturers. And there has to be an enforcement mechanism and there has to be actual enforcement taking place because the FDA, for example, complains about quality issues about supplements and they're not really doing very much about it. And the market is in a little bit of chaos.

DR. GORDON: So one of the questions, as I understand it, that we should be asking is the FDA has the regulatory authority to ask for and ensure good

manufacturing practices and you're saying they're not doing that.

MR. MARTINEZ: I would go back to the FDA and say, well, what's it going to take, what do you need to do to start taking appropriate enforcement action. Because really the wonderful thing about the natural products industry or the wonderful thing about the FDA, is once the FDA starts taking enforcement action, everybody will take notice. And anybody out there who's not playing by the rules is not going to want to get their head hammered because when the FDA -- the FDA has a very rich history of being able to hammer businesses quite effectively.

So it's almost like -- I'm not for using a sledge hammer to swat an ant but you can take a fly swatter and give it a smack to a company that's not playing by the rules and everybody is going to take notice and say, okay, I can't cut corners.

It's really not fair to the businesses that are doing everything by the book that they have to compete with substandard businesses out there. And if everybody knows that, hey, there's an equal playing field, an enforcement field, I think overall the quality is going to get better.

DR. GORDON: Thank you.

Tom, did you have anything else?

Effie, go ahead.

MS. CHOW: Tony, I like what you said and I would like to see that you would provide us with more input in those lines, written, and suggestions.

MR. MARTINEZ: Well, rest assured that I am personally and professionally committed to the work of this Commission.

MS. CHOW: Thank you.

DR. GORDON: Thank you. Thanks so much.

Next is Jay Witter.

MR. WITTER: Good afternoon.

My name is Jay Witter and I'm the Vice President of Government Relations for the American Chiropractic Association. I appreciate the opportunity that the Commission has given me to address you.

The American Chiropractic Association congratulates each of you on your appointment to the White House Commission on Complementary and Alternative Medicine Policy. We applaud the President for establishing this worthy Commission in an effort to put forth public policy that recognizes complementary and alternative medicine as a viable choice for American citizens.

In addition, we would like to thank Senator

Tom Harkin for his leadership in Congress, for all the complementary and alternative health care issues he's worked on.

As more and more consumers seek out alternatives to allopathic medicine, the U.S. health care delivery system much accept and better understand all health care options available to consumers. The ACA wishes the Commission success in paving the way for better consumer access to complementary and alternative health care.

Chiropractic is the third largest doctoral level health care profession in the Western world after medicine and dentistry. In addition, recent studies have found that chiropractic care is one of the most popular alternative health care treatments available to consumers.

The chiropractic profession has a long history of striving to be recognized as a vital part of an integrated health care system, yet even today, as much as chiropractic has been proven effective, patients are still being denied access to chiropractic care in both federal and private health care plans.

As the largest national association representing doctors of chiropractic, the ACA offers its assistance and expertise to the Commission in

putting forth the policy recommendations that will be incorporated for proven complementary and alternative therapies into the mainstream health care system.

The ACA looks forward to working with the Commission as you develop your policy recommendations.

Thank you.

DR. GORDON: Thank you.

Any questions for Jay Witter?

(No response.)

Great. Thank you. You were here this morning. We're very eager to learn more about chiropractic education and the interface between chiropractic and some of the other health professions.

So thank you. We'll be calling on you.

MR. WITTER: Thank you.

DR. GORDON: Next is someone who probably needs no introduction at all, who's been a wonderful leader in this movement, Beth Clay.

MS. CLAY: Thank you, Jim.

For those of you who don't know me, I'm Beth Clay and I am a staffer on the Government Reform Committee in the House of Representatives. I'm formerly from the National Institutes of Health where I had the pleasure and honor of working with Steve Groft and the three previous directors of the Office of

Alternative Medicine. And I am here for Chairman Dan Burton who has taken the lead in the House of Representatives in looking at the role of complementary and alternative medicine in our health care system.

And over the last couple of years we've done a series of hearings where I think four members of your Commission have testified before the Committee. Dr. Fair, Mr. Devries, Dean Ornish and of course Jim Gordon have come and explained to 44 members of Congress issues around the world of alternative medicine; access, research needs, medical freedom issues which are very prevalent in this field.

And Tony Martinez mentioned one of the issues that we're currently dealing with, and that is the plight of Thomas Navarro, a little boy whose family was denied access to an alternative clinical trial.

They are presently en route. They've been living in Mexico actually for a while taking a different treatment because they could not find an appropriate non-toxic treatment to help their child.

I wanted to get back to the root of what you're here for and to congratulate you, first, for being here and being part of a Commission that has the ability to change health care and healing, not only in this country but around the world. Because the work of

this Commission will affect every health care practitioner in this country and every health agency in every country around the globe will read the report that comes from this Commission and use it as a model of how they can improve their health care.

And as I've sat and listened the last two days to the discussion, I'm thrilled to hear -- getting back to the root of what are we really talking about. We're not talking about having a doctor's visit and getting a prescription. What we're talking about is developing a lifestyle for Americans and helping people learn how to start at the very beginning of our educational system and helping people make good choices in their everyday life so that when they come and see a physician it's for a well care visit and not a critical care visit.

And keeping in mind the semantics issue. I've learned in my lifetime. I was thrilled when Sister Charlotte described herself and described herself as a Southern woman. I also am a Southern woman. And that brings into itself a specific understanding and perspective in life. I also am the mother of four Asian-American children, which brings for them a particular perspective in life. And having a respect for different cultures and perspectives in

life is one of the things that as we look at these issues, having a respect for the different systems of healing that people choose and giving people -- honoring people in their choices.

Part of the conversation is how do we integrate, how do medical doctors integrate complementary practices into their healing system. But part of it also is how do medical doctors allow the people who come and visit them to choose other health care professionals, to stay within their own system of healing, and to respect that. And I hope that as we go through this we'll keep that in mind.

One of the things that I do in my life, and as I've gone through my own journey in looking for where I belong in life, has been becoming a hospice volunteer. And I am thrilled, Dr. Fins, that you are here.

One of the hearings we did last October was looking at improving care at the end of life through complementary medicine. And part of this aspect is what is so wonderful about hospice. It's the hospice team. The doctor is a part of that team. The patient's in charge.

You have a doctor, you have a nurse, you have a volunteer, you have a chaplain, you have a whole

team. You also have a community. When someone is in an end of life situation, their community becomes involved. How do we recreate and strengthen our communities, and through that, improve health.

How do we bring that into health care from the beginning of life and through every stage. And maybe taking that perspective, we don't have to work in the health care system we have now. We can change that. And this Commission can do that.

You have a lot of friends on Capitol Hill. We're just half a block up the street. We are here for you through this process.

I will be happy to provide to you the reports that have come out from our hearings. We've done about nine over the last two years looking at different issues, specifically, a lot in cancer. I'd be happy to provide those.

If there are other things that you need, please let us know. We would love legislative solutions. We're here to help. You have friends in both the House and the Senate. And that list is growing.

One of the things I have seen over the last two years is not only have the seeds been planted, and it's like watching a rose garden grow. You've got rose

bushes. And members of Congress, the division I look when I first came onto the Hill, they're like tight little rosebuds and different ones blossom at different times and they're in different stages. But they are all beautiful beings who are beginning to open up and bloom. And that is what's happening across this country in health care. We have a chance to blossom and improve health.

DR. GORDON: Thank you very much, Beth.

I really appreciate your being here and your consistent presence and your vision.

One thing I hope that you'll do, and then open for other comments or questions, is not only through your office which has been so active on so many of these issues, but if you'll help give us guidance about others on the Hill whom we should be contacting and asking to help us with our considerations and deliberations.

MS. CLAY: One of the things I meant to do was to give a couple of suggestions as well. And I would suggest that you all send a letter to each member of Congress letting them know that you've had your first meeting, outlining what your mandate is and asking for their input.

DR. GORDON: Great.

MS. CLAY: And I would also suggest you do that with all of the professional medical associations, the alternative and the AMA and others to let them know that the Commission has been established, that you're welcoming input and to do the same thing with citizens organizations.

Be proactive in letting people know you exist and this room will be full to overflowing the next time.

DR. GORDON: Great. Thank you.

Do we have agreement on that?

(All nod yes.)

So let's make sure we do that. And we can work on that communication and go over it and I can sign it for the Commission.

Great. That's a great idea, Beth.

We'll be coming back for more.

MS. CLAY: And I'll be happy to work at any time.

DR. GORDON: You'll be available, as we need guidance, to talk with other members and other committees? You'll be able to help us with that as well?

MS. CLAY: I'm always here for you.

DR. GORDON: Fantastic.

Any other questions of Beth? Over the last two years now, she's been able to raise some very, very important questions working with Representative Burton and with his committee about a whole host of issues related to CAM in a very broad perspective. So I think that we have a lot to learn.

MR. GROFT: I would just like to commend Beth. As she mentioned, she was a staff member of mine with the Office of Rare Diseases several years ago, so it's very nice to see her make this tremendous transition into this type of person on the Hill and a professional transition. It's nice to see her on the other side of the microphone.

So, congratulations, Beth. You've done a real nice job. And good luck.

DR. GORDON: Great.

Next is Barbara Meyerson sic).

REV. MEYERMAN: Thank you, Jim. One of these years you will pronounce my name correctly.

Hello and good afternoon. I'm very grateful to be here. My name is Reverend Barbara Meyerman.

DR. GORDON: Oh, --

REV. MEYERMAN: That'S okay.

DR. GORDON: -- I not only can't pronounce it. I can't read it.

REV. MEYERMAN: And I'm not even a doctor and you can't read my handwriting.

And, Steve, it's good to see you. I was actually at Chantilly and so this is such a fantastic -- this is -- Sandra was saying it's a dream team and I really feel the same way. For those of us that have been on the -- not so much the professional end or being part of the councils but actually out here working with the public and the people that are trying to create integration of CAM therapies, it feels really wonderful to be here. And I want to thank each one of you for being a part of this. It's very exciting.

I think that this has been very necessary because as a person that's only missed one NIH OAM or CAM meeting since its inception back after the Chantilly meeting through Wayne Jonas and you, Steve, and everyone else, it's been quite an exceptional ride. And it is like a tugboat trying to push a huge ship. And you know how long it takes to turn a huge ship.

And I think that this is the key to it because there hasn't been an entity that has the ability to create policy changes. It's mostly been focused upon research. And that's the old NIH model that we've all had. So it's like trying to cram something that's a huge Mandala and put it into this

medical model that has existed since we first had the creation of penicillin.

It's like the FDA being reformed now. The same thing is true there and all across the lines of government. It's all very necessary.

So at this point I would like to call myself a health care practitioner according to your new definition, Tom. Thank you very much.

I have called myself in the past a holistic health practitioner, the founder of a group that is expanding called the All's Well Alliance. And it's a group of holistic practitioners, CAM practitioners, including acupuncture, rebirthing, breath work, chiropractic, all different modalities. And of course, it's a very large umbrella.

So one of the things I would recommend and I believe Beth or some of the other people can provide, you need to see the history. Someone once called me the NIH historian of CAM because I had been there from the beginning and I've seen so many things created and occur.

I think rather than reinventing some of these things, there's actually been some -- and Jim, you were there to see some of this. There's been some proposals. There's been some ideas shared around at a

table similar to this at NIH and there was no ability to really create broad policies and actions. So one of the things I recommend out of that that you look at, because it's such an overwhelmingly broad scope, is that one of the things that was created by Wayne was a Mandala.

Do you remember that, Jim?

And it was a very lovely model for addressing every single facet of what you're looking at now. So you might want to go back and request the history of all of that.

Would you think that that would be good, Jim, as well, for everyone here to have some of those minutes of the meetings and different things that went on? I think it would be of benefit to kind of get up to speed on some of the history of what has occurred so that we don't have to remake it again. Because this is a group that is really recreating protocols, recreating policy, recreating a new model, into a new model that's integrated. And that's very different.

Effie, you talked about illness versus health and this being an illness center rather than health and human services. And several people have addressed that.

One of the things about the history, I have a

pretty good memory about all the different NIH meetings, believe it or not, and one of the things that comes to mind that I'd like to share with you is that there was maybe three years ago -- correct me on this. It's in the minutes. There was a vote that passed on creating and, believe it or not, a non-disease specific center. That was as far as NIH/OAM could go at the time. That was as radical a statement as could be made. So that it would not be a center generated based on a disease protocol. It's in the minutes.

There are thousands and thousands of years and pages of protocols for acupuncture and other Eastern medical modalities where we could just simply get somebody to interpret it from another language and have tons and tons of information that has already worked.

It might not be up to the rigorous standards exactly of research that is typical of NIH but I'm sure much of it could be very, very useful. That way we don't have to reinvent the wheel here in the United States. We can look at all the things that are out there that are working in other countries.

When NIH Office of Alternative Medicine went after two or three years of creation to the first world health congress, people actually came up and said we do

not understand your name. It was confusing to them. Do you know why? Because CAM was health care. It wasn't alternative.

And so really what we're looking to do here in the United States, we're like the kindergartners getting up to speed on some of the integration that's occurred in other parts of the world. And you can see that effect and the results, which is everything, when you look at the difference in our health care and in the results of how many people are dying from different diseases, from medication or whatever.

So I ask you to please look at this, as well.

One other thing. In terms of training, I'm really thrilled to hear you, Bill, talk about cooperative work because not all physicians are going to make great adjustments and do chiropractic or anything else. They're not meant to be that. It's meant to be a team effort. Because we are a manifestation of mental health, emotional health, physical health. And all of these things need to be addressed if we're going to truly address whole health with an individual.

So I thank you very, very much, and it's joy to be here. And I will do anything in my power to get things out to different groups that I'm connected with

on the internet.

I think it would be nice to have the White House interfacing and have something out there. This meeting was not put out very well to the public so that there would be more practitioners that would come.

So thank you.

DR. GORDON: Thank you. And than you for your participation and your sense of history.

I think that we're very clearly on the track of the whole issue of wellness and how to make that manifested in all of our recommendations.

The other thing. Once again, the way things happened, it was impossible for us to get out word any earlier than yesterday, simply because of the clearance procedures that came through. So in the future, we are completely committed to making sure that word is out far in advance to as wide an audience as possible about these meetings and we welcome people.

We also welcome, in the meantime, input via e-mail and we will have town hall meetings at various places around the country which will be solely devoted to sort of testimony and back and forth from the community. And we'll ask you and all of you to help us bring together groups of people in those various locations around the country. So, we're very much

committed to that.

Any other questions for Barbara?

(No response.)

Okay.

And our last person who'll be speaking is again someone who's been very involved in this process for some time, Maury Silverman.

MR. SILVERMAN: Hi. I'm Maury Silverman and I've been involved in alternative health care issues for years. And I'd just like to comment on many items I've heard here since yesterday.

Most recent was this morning. Jim talked about looking at the malpractice system. I think that would be helpful. Here you have a system that I would best compare to a best Cold War term, mutually assured destruction. It makes honest people dishonest.

And may I offer a suggestion? Back in 1973 the Nixon Administration's HEW, the original name for this place, had a malpractice commission. Dig out their recommendations and see how much of that was actually implemented in all those years.

Attached to that is like a three inch thick book of appendix of related papers. And in that there's a chapter on alternatives to litigation. And one complex sentence. It might have been the solution

to the whole thing. And it read as follows. There's no rule of law nor precedent of public policy that precludes arbitration in the medical/legal interface. And I wonder if arbitration would be a more logical way to handle these things.

Malpractice probably would be divided into gross errors which are the ones that trial attorneys wait for and create terror and inflate the medical care delivery system's cost. And just majority of it is probably things that could have been done a lot better.

And CAM, the whole idea and phenomenon of CAM is doing things better by adding more modalities. It's not an either/or phenomenon. It's a both/and phenomenon. You have a problem in the center of the wheel and there are a lot of ways to approach it. And the more of these different modalities you have, the opportunity and the system capacity to provide a person, the faster and better problem solving you get for a given disease entity.

Next is the idea of clinical research. I personally think that we really need the next NIH director to be somebody who's actually had a career in clinical medicine. National Academy of Sciences has published a lot of material from the early '90s in gaps in clinical research and we really need to get back and

look at the original mandate for NIH, I think going back to Frankly Roosevelt's time, which said that it's supposed to be research that will benefit the health of the American population.

A lot of NIH -- all of it has moved science forward. No doubt about that. But a lot of it is kind of like the National Science Foundation. And we need more clinical research and a director of NIH who has practiced clinical medicine and can translate that to the delivery system. Because the changed with managed care and the business aspect, a lot of your academic medical departments and teaching hospitals and academic medical centers and medical schools have lost resources that benefit teaching, that enable faculty and participating physicians to devote the time to teach. And I think you've got to make up this gap through clinical research that comes from NIH and look at their very significant budget increase to really be devoted to clinical research.

Next is ideas -- you've talked about methodology. We need more in the way of multi-factorial methodologies to test things like natural products, which is a synergism of a lot of things, like in a botanical.

You mentioned, Effie, that it won't make much

difference to pull one active ingredient out of a botanical. It's the mixture and the synergism. So we need methodologies to be able to test that.

There's a difference between the nutritional and the pharmaceutical model and it's got to go way beyond the traditional scientific method of dependent/independent variables.

You're right. You need to identify the gaps in the research, identify the good body of research that is there and respect the difference between Eastern and Western medicine. Western medicine, they don't want to put anything into the marketplace until it comes out of the lab and we can analyze why it works ad infinitum, ad nauseam, often.

Eastern medicine is often based on empiricism. We know this works. Acupuncture is an example.

There was a good comment yesterday that we need to explain these things. Why is Chi, the energy.

I remember when I was medical student, I started running into that. The person who taught me most when I was a medical student was probably someone we named Abra, who was the cadaver I dissected in gross anatomy. And I learned then that every organ system, every muscle group is enveloped by connective tissue,

fascial planes, fascial layers. And this is what really corresponds to the meridians and acupuncture points.

And in all that connective tissue, you've got melanin pigments in all your connective tissue. And there's a long article in one of the old journals, "Melanin, the Organizing Molecule." It's like an electron transport chain. That's where your energy is mediated.

So I have a firm belief that all these modalities can in fact and will be explained in terms of all the basic and clinical medical sciences they teach in every medical school.

Information is an important part of this. People are empowered by information now and you've got to look at that. We have often an outdated regulatory model. It's not any longer like the Age of Franklin Roosevelt when regulation -- there was an educated class and then everybody else, and the educated class made decisions for all of society. Now every individual is empowered by information at the touch of a button on a computer. The internet. And we need to reformulate for this age and let it be both a bottom up and a top down phenomenon.

You're recent conference on integrative

cancer therapy was a good example of bottom up, of practitioners from mainstream institutions showing up. But this is a good Commission because you now have an opportunity to make recommendations from the top down so it all meets at the center.

I appreciate what you're doing and I just ask you to bring it along a little more effectively, a little further, and focus on some of these things.

Thank you.

DR. GORDON: Thank you. Thank you very much.

Any questions or comments for Maury?

(No response.)

DR. GORDON: Great. We appreciate your attention and your thoughts.

So this is the beginning of the interchange. This is going to grow over time and we welcome any or all of you back. Next time we'll have a couple of hours of comment. Please feel free to keep in touch with us at any time, communicating with us, telling the Commission what your thoughts are about what's happening, what we ought to be considering. And we look forward to this ongoing dialogue.

That's the end of the time for public comment.

Steve, we have a couple of issues and let's

go through them. And then we'll be ready to conclude the meeting.

MR. GROFT: We talked about the next meeting. The next whole meeting of the entire group will be the October 5th and 6th dates most likely here in the Washington area. And the announcement will go out much earlier and we will have a greater effort to --

DR. GORDON: I think they're not hearing.

MR. GROFT: Is this coming through?

DR. GORDON: Is it coming through?

Beth, Sandy? We want to tell everybody. Barb. We're meeting October 5th and 6th is the next full meeting. Just want to make sure all of you know as well as everybody up here knows about it.

MR. GROFT: And so we will get the announcement out and we'll be communicating with you directly. Those who registered today will be getting an announcement of the meeting. And as soon as our website is up and active, we'll be informing the world of this, as well.

I think between now and then we expect to hold a couple of town hall meetings. They will be announced as well. And we'll make every effort to contact you and for you to help us contact people at the local areas.

We've talked already about the possibility of a town meeting in San Francisco and San Diego. Several Commission members have indicated a willingness to join us there in New York. We've already been talking about later on, another meeting.

So we expect to do several town hall meetings throughout the country, not just in metropolitan areas.

VOICE: Make sure you do middle America, too, please.

MR. GROFT: I'm getting to that. It's not just going to be the large --

DR. GORDON: Columbia, South Carolina.

MR. GROFT: I think the suggestion was made for utilizing the services of some type of marketing firm to help us. But I think we all know where we should go and I think the Commission members will tell us where else we should go to hold our meetings.

Everyone goes to the Coast. They go to Chicago. They go to Denver. They go to Dallas. I think it's incumbent upon us to go other places and to really capture all of America, not just the large cities and not just those who happen to know about complementary and alternative medicine or those who have access to the internet and can gather us. We have to do a better job of going out to where there isn't

access to the internet and those who don't know about the benefits of the services that are available through the interventions. That's our responsibility and we'll be spending a lot of effort getting out to all the populations of the country.

DR. GORDON: And we do welcome your suggestions about places to go and people to contact about that.

MR. GROFT: The other things. We're almost finished with the agenda unless you've got any questions.

We talked a little bit about the types of meetings we're going to hold and the like. So -- a few position papers or reviews that we'll have done for the Commission's benefit and we'll be working on those as we go along, too.

MS. CHANG: Last night I think it was mentioned that we might want to consider, in addition to the town hall meetings, looking at a chat time on line with the Director, the Chair, or any one of the Commissioners. That people, for example, in college campuses or elsewhere might be able to chat on line and we could offer that technology as well. So any other suggestions, and a beta suggestion like that, please do bring them forward so that we can see the feasibility

of that.

And I still need two checklists over there.

MR. GROFT: We are considering in the future having these actual meetings be live on the internet so we're going to look into the expense of that effort and communicate that out more broadly as well so it will be much more accessible to the public.

DR. GORDON: Anything else?

MR. GROFT: No.

DR. GORDON: So our next step -- there will be a couple of other steps. We will act and get out a communication to all members of Congress, to major health care organizations and associations and citizens groups about the existence of the Commission. We will be sending all of you soon a summary and some ideas about how we're going to proceed. A summary of the meeting and ideas about how we're going to proceed for the next panels on the four topics that we covered, as well as opportunity to talk among ourselves about our overview, our philosophy, the world view of the Commission and of CAM.

We will be planning meetings. We've tentatively -- Dean and Effie and I have tentatively scheduled a town hall meeting in San Francisco on September 8th and we'll be talking. Joe and Bill and I

are going to talk about meeting in New York soon. And Buford and I were talking about a way to meet representatives of many of the Native American groups at one of their health conferences. And we welcome opportunities to meet, and we want all of you to be thinking about places and times and ways that we can meet with other groups as well.

The other thing is that let's be in touch with each other. There'll be discussions on the phone. We'll plan conferences calls pretty soon, right, about -- especially soon about the research group, which will be the next meeting on the 5th and 6th. The group of people who signed up to be part of that, there'll be a conference call fairly soon.

There will be conference calls involving and ideas about position papers that we want prepared that will come out of this meeting, and then will come out of the back and forth on the conference calls.

So we're going to be moving ahead. We have each others' phone numbers and have each others' addresses. Please be in touch.

Commission members, please feel free to be in touch with me any time, any way. And I'll take the liberty of doing the same if that's okay.

And I know Steve and Michele will be

available and will be working together here.

Anything else?

MR. CHAPPELL: A clarification, please, on the press release. I believe you're going to be the conduit for any discussion with the public media. On the other hand, I heard you say we could do what we want with a press release. So it's difficult for me to do something with a press release and not be dragged into a conversation with the press about what goes on here. So it really doesn't work for me to promote this, my involvement in this on the one hand, and not have anything to so. So I don't know if that's true of others, but I will not be able to do anything with a press release because it will draw me into discussions which I believe you would like to be the focus and spokesperson for.

DR. GORDON: I think there are two aspects of it. The way that I think it makes sense, it may not make complete sense but I think it makes pretty good sense, is that everybody who's on the Commission is here because they think it's an interesting and exciting and an important event and process.

MR. CHAPPELL: Speaking for ourselves. Right.

DR. GORDON: And I think that you can speak -- everybody can speak from his or her own point of view

about your involvement. My role is to speak, as I did this morning, to speak for the Commission. This is who we are, this is how we're moving ahead.

So if we can make that distinction that's fine.

MR. CHAPPELL: Good. Thank you.

DR. GORDON: And if somebody wants somebody to speak for the Commission, please refer them to me. But also feel free to say I'm a medical ethicist and I'm an internist and I think this is very important, or I'm a businessman and this is important.

DR. PAZ: Also, what I was thinking is that we could be really good focal points for entering lots of information and folks' input into this Commission as well.

MR. GROFT: I think you can always give your perspective as a member of the Commission, your own personal perspective, what you feel is important. That's the embodiment of what we're trying to do here. And you are certainly entitled to give that to any of the press members. Anybody who calls you, you can talk about your own personal involvement and your own personal direction and perception of what we're doing, whether you like it or you dislike it, positive or negative. That's your right.

So we do not restrict anything. We don't want every Commission member saying I'm speaking for the Commission, but your own personal perspective certainly is welcome and agreed upon.

DR. GORDON: Steve, are we going to get out a press release now about what's happened in this meeting? I think we should.

MR. GROFT: Probably once we get the summary together from the meeting we'll put some of this out that highlights our schedule of events and the series of activities that we'll be involved with. So it will be more than just a short press release but we want to say you're planning a town meeting for such-and-such a date; our next meeting is such-and-such. Here are some of the issues that we will discuss.

We'll be working with the press people to help us formulate that announcement.

DR. GORDON: As we get out press releases we'll send them to all the Commission members so that everybody will have whatever comes out.

MR. GROFT: The same with the letters that we'll be sending out to -- as it was suggested -- to members of Congress informing them of our activities, as well as the professional societies. These are all activities that we will be initiating.

MS. CHOW: And you will include the town hall meetings in your press release?

DR. GORDON: Yes.

MR. GROFT: Right. And that will be a special announcement itself coming as well.

MS. CHOW: Can you give us some guidelines as to town hall meetings in our particular areas? Will we want to involve the governor, the mayors of the cities, from there to the local community people?

DR. GORDON: I think that's a wonderful idea. I think that each one will probably be somewhat different and I had not thought of that but it's obvious and it's terrific.

So I think that what we'll try to do, what we will do, is with the first couple we'll develop how we do it, and then as we do each one we'll let everybody know how we've done it. And that will be something for people to build on.

So if we can talk about who to involve and how to do that, then we'll kind of build a body of knowledge about how to create town meetings.

MS. CHOW: I know the Congress people and the Senators and the mayor have been much involved with activities with us, so we would involve them.

MR. GROFT: That's why *I* think our

conversations with you -- for you to identify who are the local individuals that we should contact. And I think we also will identify people who we need to contact. For example, those in the state government who are responsible for licensure and credentialing. We want to make sure that they are invited to attend. The providers of insurance and the payors, we want to make sure that they are available and they're aware of what's going on.

So looking at the issues, we then will try to identify the players that we want to inform of our activities, as well as get their input into our questions that we will develop. Because we will develop a series of questions for people to address at these meetings.

MS. CHOW: I hope the questions will kind of run in the same vein as our discussions so that it's a consistency of what our discussion is and then the town hall.

MR. GROFT: They will but they'll be a little bit different because we want to get their perceptions and their needs so that we can come back and formulate policy recommendations.

MS. CHOW: But it will be still on the same subject.

MR. GROFT: Right.

DR. GORDON: Well, no. I think the subjects will be very different, to tell you the truth. And I don't know ahead of time what they're going to be because there may be a very different issue in the Native American community in Oklahoma than there is in an urban setting in New York.

MS. CHOW: Of course. Yes.

DR. GORDON: And there will certainly be differences between the health -- there may be a preponderance of health professionals who for whatever reason will show up at one meeting and a preponderance of mothers with young children at another meeting.

So I think the issues are going -- and that's part of the beauty of it is that we expect very -- we want to open it so that people can address the issues that are important to them, just as Tony raised an issue that was somewhere in the back of my mind and maybe in the backs of some of your minds. We didn't bring it forward and then he brought it out. And just as Beth made the suggestion about communicating with Congress.

I think this is what we want to encourage is all the things that we can't think about in advance and really be open to those.

MR. DEVRIES: Excuse me. A question regarding town meetings. Some of us, myself in particular, work with providers and health plans locally all across the country and certainly have the ability, for example, in the San Francisco Bay Area, our company provides complementary and alternative medicine benefits for most of the health plans up in the San Francisco Bay Area. And we contract with over 1,000 complementary and alternative medicine providers in the San Francisco area.

And so would you like other Commissioners to support those efforts in other parts of the country even though we're not located there.

DR. GORDON: Absolutely.

MR. DEVRIES: Be more than glad to, at least from our perspective and involvement.

DR. GORDON: Great. Okay.

Anything else?

(No response.)

Thank you all very much. I have to say this is a wonderful group. I really am enjoying our work together and I really feel like with our remarkable diversity there's also a wonderful respect and a very exciting kind of convergence that we're experiencing.

So it's great to be with you and look forward

to seeing you next time.

Thank you all. And thank you, Michele and Steve and Jerry for making it possible for us to move forward.

MS. CHOW: I just want to thank Steve and Jim for running this thing so well. I think they deserve applause, and the staff.

(Whereupon, the proceedings were concluded at 2:20 p.m.)

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This is to certify that the attached proceedings before: WHITE HOUSE COMMISSION

In the Matter of:

PLANNING MEETING

were held as herein appears and that this is the original transcript thereof for the file of the Department, Commission, Administrative Law Judge or the Agency.

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