

1 raised by some of the CAM therapies?

2 For example, taking a look at something that
3 was discussed earlier, the use of combinations of herbs,
4 the notion of synergy among herbs, or the whole plant
5 product versus an extract, in fact, a synthetic version
6 of an extract of a plant, and also issues related to
7 energy, so-called energy medicine, and looking at some of
8 those phenomena. I am wondering if you are considering
9 those.

10 DR. CASSMAN: Well, to some degree. For
11 example, our involvement with one of the centers is to
12 look at bioavailability issues of how complex herbal
13 systems with multiple components actually find their way
14 through the body to wherever it is they are going, or
15 whether they are excreted. There are technologies that
16 can be used for that. We are certainly interested in
17 that.

18 The extension of natural products chemistry has
19 not been very active recently, but it is an area in this
20 field, particularly, that I think we would have a great
21 interest in. In terms of field issues, let's take the
22 effect of magnetic fields. That is an obvious one, I

1 would think. In fact, there is a great deal going on of
2 that. It just doesn't happen to be in my institute. It
3 is perfectly reasonable, I think, that it is in the
4 Environmental Health Science Institute.

5 There is a lot of support. It has more to do
6 with the organization of NIH than any interest we may or
7 may not have, but because of external fields and their
8 effects, this came largely as an outgrowth of the concern
9 about EMF, electromagnetic field strength, on systems and
10 the deleterious effects of that, but it has extended to
11 other issues as well. As I say, there is a good bit of
12 support in it. It just doesn't happen to be in the
13 General Medical Sciences Institute.

14 DR. GORDON: Thank you.

15 Because we only have a minute left, I am going
16 to take the liberty, and Tieraona is here for the first
17 time and has not spoken, giving her the priority to ask
18 the last question.

19 DR. LOW DOG: What I have been listening to,
20 part of it is about education and collaboration, and
21 about how we get complementary and alternative
22 practitioners into doing research. I certainly don't

1 think we need abandon the control trial in biologics,
2 botanicals. Dietary supplements fit well within the
3 double-blinded, randomized control trial, even
4 combinations.

5 However, what I have also been hearing from a
6 number of the Commissioners is that there is a number of
7 our modalities that don't fit well into that gold
8 standard. Some of them are difficult to double-blind.
9 Many of them have individuation of therapies and perhaps
10 we need to look at some of the psychotherapy models,
11 other things like that, that actually also have
12 individuation of therapy by nature of its field, but have
13 to fit within some sort of standardization to be able to
14 submit to trials.

15 I would like to know the feasibility or where
16 we would look in this country, but in Germany they had a
17 series of seminars that were put on at a medical
18 institution that was available just for CAM
19 practitioners. It was over a three year period and it
20 brought them in to teach them from the very basics how to
21 do research. They worked with them on the problems of
22 research and individuation in that. What they ended up

1 with and what their whole goal was, was to develop a
2 strong core of experienced and dedicated CAM
3 practitioners, not just collaboration, but people that
4 spoke that language that could then go and do the
5 research and do quality research.

6 I wondered is there a method or a mechanism or
7 who would take up that sort of ball in the United States
8 because I think that is very important. I think that
9 that would really contribute to the growth of better
10 research and address some of the considerations that CAM
11 practitioners have.

12 DR. COATES: Let me try and address that a
13 little bit. Since Dr. Straus I don't think is here I
14 could probably speak for him and say that probably the
15 NCAM is one of the organizations that perhaps is good way
16 that should be approaching it. I say that because it
17 turns out that we have just published recently, along
18 with 12 other institutes at the NIH an announcement for
19 planning grants to train minority-serving institutions,
20 investigators at those institutions in clinical research.

21 A similar thing can probably be done for
22 complementary and alternative medicine research. In

1 fact, we specifically included not only M.D.s, but also
2 osteopaths, chiropractors, doctors of naturopathy and so
3 forth in the announcement specifically by name. So I
4 think it is feasible. It is not going to be easy by any
5 means, but it can be done.

6 DR. GORDON: Thank you.

7 We have time for two brief questions from Joe
8 Fins and then Wayne Jonas.

9 DR. FINS: Secretary Shalala recently wrote an
10 article in The New England Journal of Medicine a couple
11 of weeks ago about research protections and balancing
12 access versus protections and having good layered review.

13 I am just wondering in your experience, you
14 know, intramurally and extramurally, the adequacy of the
15 training of IRB members to competently review such
16 protocols that are perhaps out of their normal
17 disciplines.

18 Let me target, is there a need for training
19 along the lines of the sort that the Secretary proposed
20 for IRB members, including CAM modalities as a
21 supplemental to that perhaps new mandate?

22 DR. LENFANT: I have to speak to that because

1 we have been involved with an overall training trials in
2 alternative medicine and I am not aware personally of any
3 hurdle at the IRB level. In the past, the review groups
4 were assessed to scientific merit of those things, are in
5 great need of broadening their views. Should I put it
6 that way? That is a real problem that we have to deal
7 with.

8 What we have done in such specific instances
9 was to bring as part of the review group, individuals who
10 are experts and have interest in issues of alternative
11 and complementary medicine, but it is a very difficult
12 process. I have to admit that.

13 But you see that is a point that I was trying
14 to make earlier. As long as you don't educate where
15 education begins, it is just not going to work. You know
16 that the nutritionists to accept nutrition as something
17 of any importance in medicine.

18 DR. GORDON: Thank you.

19 Wayne.

20 DR. JONAS: I want to thank the panel for
21 coming. I think for those on the Commission who are not
22 aware of it, these folks, as well as a number who are not

1 here at NIMH and a number of other institutes really are
2 the people that are moving forward in this research area
3 without a mandate. I mean, they are doing it on their
4 own with their own efforts, using resources from their
5 own institutes. I just want to commend you all and
6 congratulate you all for those efforts.

7 I would like to make a request and that is that
8 some of the comments that were made, especially by you,
9 Dr. Lenfant, and Dr. White at the beginning and others,
10 perhaps didn't have enough detail to make them about some
11 of the issues that address the specific questions, the
12 obstacles, the issues that you addressed.

13 If we could get some of those in writing
14 because a lot of those were not in here, I think it would
15 be extremely helpful. Jeff, your summary was fabulous.
16 I would love to see that in writing. This applies to the
17 others as well.

18 Also, in the training areas, if they could give
19 us some specific suggestions as to how your agencies,
20 centers and institutes can do training because that is,
21 obviously, a common theme across all of these areas.

22 I have a specific question for Dr. Cassman and

1 that is that I would be really interested to know how we
2 can incentivize or motivate or bring the basic
3 scientists, the good core, molecular and cellular
4 biologists out of the woodwork in this area. Because as
5 I go into the institutes, Scripps and various other
6 institutes that are doing core basic science research,
7 what happens is that they talk about the exciting kind of
8 low level laser work that they are doing, for example,
9 like this.

10 Then later on, either over dinner or a drink or
11 as I walk out of the room, they come and say, you know
12 what, this really might have applications in terms of
13 acupuncture. I have actually read some research over in
14 Japan where they used this type of thing and showing
15 amazing results. But I don't know how to do this kind of
16 research.

17 I said, well, why not? Well, my director
18 wouldn't hear of it. Okay? There is still a taboo, if
19 you will, communication taboo. Part of it is training
20 and part of it is just stigma in the basic science area.
21 I would love to hear are there some ways in which this
22 community can be really incentivized and brought into

1 doing good science in these areas.

2 DR. CASSMAN: Everything you said is absolutely
3 accurate. It is difficult. It is not unique by any
4 means, to complementary and alternative medicine. It is
5 true for any new discipline that is emerging. I am not
6 saying this is new, but at least coming into the scope of
7 fundamental research that we are particularly involved
8 in.

9 We have some programs that attempt to make that
10 a little bit easier. We have a program, for example,
11 that is called High Risk/High Impact, which actually
12 solicits applications that are outside of the mainstream,
13 if you will. We go out of our way to try and ensure that
14 that is supported.

15 I think the bottom line really is, and I have
16 heard it mentioned by others as well, you need a
17 definable research question that can be addressed in a
18 manner that is measurable. If you can't do that, there
19 is no hypothesis to be tested at this stage. If it is
20 just information gathering, you are not going to find
21 very many good fundamental scientists interested.

22 There has to be something there that one can

1 actually quantitate in some sense. It has to be
2 measurable by whatever, you know, as long as it is a
3 modality or a tool that can give reliable and
4 reproducible results.

5 Once you have that and once you have a question
6 that can be addressed, there is really, I don't think,
7 any particular barrier to that. But that is hard. It is
8 not easy in any form and I think you are going to have to
9 work very hard to find out what questions are amenable to
10 that approach.

11 Again, I am talking now just from the point of
12 view of my institute and many of the people that we
13 support and deal with. We primarily deal with the
14 question not of what, but how.

15 I think Steve Hausman said earlier you need to
16 demonstrate that there is a phenomena that can be
17 investigated before you ask yourselves how are you going
18 to do it. Why is a higher authority echoed? We don't
19 deal with that. But how is an important question and we
20 need to have a definable process. We need to have a
21 definable question and a methodology that tests it, that
22 is quantitative and reproducible before anybody will be

1 interested.

2 DR. GORDON: Thank you very much, Dr. Cassman,
3 and thank you all. We really very much appreciate your
4 contributions. I would like to echo what Dr. Jonas has
5 said. We welcome not only clarification of specific
6 issues that you raised, but any other comments you would
7 like to give us in writing and we would like to feel free
8 to call on you, either formally or informally, for
9 further advise and suggestions.

10 Thanks again.

11 We will take a 15-minute break. We will come
12 back precisely at 11:05.

13 [Recess.]

14 DR. GORDON: This next panel is on academic
15 centers and support for CAM research. Once again, we
16 will ask each of you to speak for 10 minutes and then we
17 will have a time for questions from the Commission.

18 The first speaker is Dr. Alfred Fishman.

19 **Session III: Academic Centers and Support**
20 **for CAM Research**

21 DR. FISHMAN: Thank you very much for inviting
22 me. I am in the terrible position of being forbidden to

1 use slides.

2 [Laughter.]

3 DR. GORDON: We are doing some research on
4 stress.

5 [Laughter.]

6 DR. FISHMAN: The second problem is that I
7 agree with almost everything I have heard before, which
8 really disarms me.

9 My charge, as I understand it, was to give you
10 a brief a description of what we have done at the
11 University of Pennsylvania to remedy some of the
12 questions that the people are receiving about, how do you
13 do research and how does it fit into an academic health
14 center.

15 About 3 years ago, our dean-CEO, after some
16 preliminary discussions, decided that there should be a
17 central move on the part of the administration to find
18 out, where do so-called complementary alternative
19 therapies fit into the academic health center.

20 I don't have to reaffirm for you the mission of
21 the academic health center, which bridges education,
22 clinical, and research. He asked me to lead the effort.

1 I refused. My background is entirely one of research,
2 clinical investigation, and there are people here, whom I
3 can give you references, who will at least testify that
4 that was my previous life.

5 After awhile, I became interested, and the
6 approach that we took was to set up a working group which
7 consisted of eight people, who were really practitioners
8 of complementary alternative therapies, and eight hard-
9 nosed scientists, and two administrators. When we first
10 started to meet to discuss, where do these complementary
11 alternative therapies fit, we were arranged just the way
12 we are seated right now.

13 All the people who believed in CAM sat on the
14 left. All the others, the right, and I sat here. By the
15 end of the year, it was impressive, if nothing else, to
16 see that they didn't care where they sat. They began to
17 understand each other, and that outlined one of the
18 problems, of course, with the acceptance of what CAM has
19 to say.

20 What we did is we went through a process, which
21 was dictated by the dean, as though we were setting up an
22 institute, a center or a new department. Therefore, we

1 went through reviews. Dr. Jonas, for example, was
2 present at one of the reviews. What we did about the
3 halfway mark, we convened a retreat and we discussed in
4 open forum, probably 100 people, the head of the
5 Institute of Medicine was there, Ken Schein. Roger
6 Bolger was there, who some of you may know; leading
7 people who were hard-nosed.

8 We presented what we thought we were trying to
9 do and the commentator at the end was Dr. Osborne, who is
10 head of the Macy Foundation and everybody gave us
11 applause. After that, we took a proposal and went up
12 through the university channels, departmental chairman,
13 institute directors, administrators. We went through all
14 the command performances, right up to the president of
15 the university.

16 The end result is that we were accepted. We
17 came up with two volumes and I have sent copies of that
18 and I have also provided a brief summary of our
19 conclusions. What I would like to tell you now in a few
20 words is what we have come up with as a basis for
21 discussion.

22 What we have come up with is that there are

1 certain general considerations that have to be taken,
2 clinical, educational and research and the most important
3 is they are all interlocked. Dr. Lenfant stressed the
4 point of education. It is just as important to have
5 wrapped into it the clinical and the research and they
6 have to interrelate.

7 So as a general concept, we said we have to
8 develop all of these simultaneously. The general
9 approach is the institute will remain committed to a
10 scientific approach to CAM, as it is for everything else,
11 but it also believes that the scientific approach is
12 applicable to any one of the topics that we can raise in
13 CAM. I will defend that in the discussion if you would
14 like to challenge that.

15 We did heavy research on the Cochran
16 Collections, which are informative, the American College
17 of Physicians, reports on evidence-based medicine. We
18 see no problem with incorporating these into the
19 scientific establishment that we call so-called Western
20 medicine.

21 In clinical practice, we recognize that
22 practitioners have a different responsibility from those

1 of an academic educational institution. The academic
2 educational institution has to be rigorous in what it
3 recommends. So it is how staff uses it, patients get it,
4 et cetera. The private practitioner, who is well-
5 educated, knows what it is that the education has
6 provided and then can use his or her own head. I mean,
7 if you find out that there are certain therapies that
8 work in your particular practice and they do^{it} harm, et
9 cetera, we see no particular reason why we should try to
10 inhibit that.

11 We took a poll at the start of our study of
12 1,500 physicians, who related to our health systems. We
13 found that one-third were using or practicing so-called
14 complementary therapies. We have made a breakdown of
15 what they did. Many of them were in nutrition. In my
16 department, when I headed rehab medicine, we did
17 acupuncture. So there was a lot of activity and each
18 step in the process, the faculty has given us our
19 blessing.

20 I don't have many copies of these two volumes,
21 but we did provide you with a two-page summary of what
22 the results were. We said up at Penn that we would not

1 build a big theater, where we would practice
2 complementary medicine. We said that we would do that as
3 a distributed virtual system, recognizing that different
4 people will do different things at different places. We
5 took advantage of the fact that we have a woman's health
6 center. We developed a program there.

7 WE have a cancer center. We have developed a
8 program there. We have a rehabilitation program for
9 wellness. We converted that from a rehabilitation entity
10 to one that would promote therapies, such as tai chi,
11 massage, et cetera, but probably our biggest contribution
12 was we described a method by which you could incorporate
13 all these. We set a steering committee, which still
14 exists, and we heard the question before, what does an
15 IRB do. If the IRB gets an implication it doesn't know
16 how to handle, it goes to the steering committee.

17 That steering committee includes people who
18 understand CAM and if they don't know, they can know
19 where to go get people who understand it. So we have got
20 an advisory group to the process. The credentialing
21 process is exactly the same as if you were to do brain
22 surgery.

1 The departmental chairman says I would like to
2 credential, allow, this person to do any one of the
3 techniques. Great. The steering committee looks at it
4 and says this is fine. Has it been approved? Has it got
5 state licensure? Has it got this? These criteria varied
6 from place to place, but the mechanism just fits very
7 smoothly, as long as you have got the steering committee,
8 so-called, which offers advice, which is taken by the
9 departmental chairman, by IRBs, by everybody else.

10 With respect to education, this has been great
11 fun because what happened is we have punctuated our
12 curriculum by putting into the curriculum at the proper
13 place, where complementary alternative therapists have to
14 be considered. So in pharmacology they see certain
15 things that have to do, for example, with depressants or
16 antidepressants, et cetera.

17 We have minimized the number of lectures. We
18 have responded to students. There is one group of 100
19 students now, who have a Qi Gong program, which is
20 prevalent. We have hired licensed yoga instructors to
21 train our physical therapists so that they can do in
22 rehab medicine some of the things we have been talking

1 about.

2 In the back of this book, we have gone through
3 the credentialing process as an example for acupuncture,
4 for massage, tai chi. Each one of these has gone through
5 the standard process. So I may be oversimplifying it,
6 but truthfully we haven't seen any problem.

7 With respect to research, we have done
8 something that I think may interest you. We have formed
9 partnership with our Center for Epidemiology and
10 Biostatistics, which is very much concerned with outcomes
11 research. Now, you can measure anything in the form of
12 therapy by getting a population and testing its outcome
13 or you can look, as some of the people have done, join
14 forces with the University of Health Sciences, which is
15 committed to the exploration of the contents of herbs.

16 We have got several people now working, who are
17 physicians, finished their residency in medicine, who are
18 now taking master's degree in epidemiology and
19 biostatistics for outcomes research, two year program,
20 and they have partnered. For each one of these people
21 what we have done, we have one CAM person, who really is
22 a mentor, and we have a partner in epidemiology and

ended
Recommend
here

1 biostatistics so that each person who comes into the
2 program has a partnership of somebody who knows the
3 business and somebody else who knows how to evaluate.

4 So far that has been very successful. We now
5 have several other people that have come up the road, who
6 are doing this. We even have a program called the "For
7 School" program, where a third year student, who becomes
8 interested, can take a year out of research under proper
9 mentoring in this particular institute.

10 Am I running out?

11 DR. GORDON: Yes.

12 DR. FISHMAN: Then I won't tell you all the
13 obstacles we have. I won't tell you how we solved them.
14 But there were obstacles. There were many things to be
15 overcome, but we can leave that for later.

16 DR. GORDON: I think we will be coming back
17 later, particularly to some of the issues you just raised
18 about how you are facilitating research.

19 Thank you very much.

20 Dr. Daniel Federman.

21 DR. FEDERMAN: I think it is interesting that I
22 am paired with Dr. Fishman because we have a very similar

1 outcome, but a radically different almost opposite
2 process. Instead of starting centrally, as they did, the
3 other process could be described as recognizing what had
4 started individually and what we did was recognize
5 something that had already been created by an
6 entrepreneurial young faculty member.

7 In our system, that is a much more likely way
8 for something new to get started than the rational
9 approach that Al referred to.

10 [Laughter.]

11 David Eisenberg was the young man in internal
12 medicine, who was trained in China and in Chinese after
13 his training in this country. His paper on the
14 prevalence of use is really one of the sentinel events in
15 the development of the field. He had patiently on his
16 own acquired independent funding. Although the focus
17 this morning has been entirely on the federal government,
18 I don't think we should neglect the importance of private
19 philanthropy in getting things going to a point where
20 federal funding, based on other criteria can be used.

21 He had established an NIH-funded program. A
22 lot of things happened at our school in that way.

1 Primary care, aging, ethics, AIDS, nutrition, substance
2 dependence, domestic violence are now all established
3 school programs, but started with the energy of one or
4 two people.

5 The diversity of our institutions plays a role.
6 We have a VA, a health maintenance organization, several
7 cancer centers, several specialty and general hospitals.
8 Somewhere out there someone gets a good idea and starts.

9 The other thing I would like to emphasize as
10 potential solutions to your concerns are the roles of
11 young people, not bearing established prejudices about
12 everything, but much more open and much more
13 interdisciplinary in their thinking. Therefore,
14 educational efforts, courses for medical students and
15 students in other disciplines are a way to think about
16 interdisciplinary research emerging in the future;
17 whereas, if you go to some established person and try to
18 change his or her habits, it is much more difficult.

19 Finally, seeing that the field was maturing,
20 that we were being left out, that the clinical use was
21 very widespread and that we had somebody in our own
22 institution who was ready to lead, we went through the

1 step of creating a division, not a department but a
2 division, a division that is interdepartmental. It is
3 inter-institutional and it cuts away from some of the
4 competitive disincentives, which are very strong in our
5 school.

6 The establishment of the division went through
7 some of the steps that Al talked about, including the
8 appointment of real opposition, people who didn't want it
9 to happen, and getting them involved in it. We had
10 several open meetings, where the opposition was
11 deliberately invited and given plenty of time to speak.

12 We set up a delphi process and had three cycles
13 among faculty about what should the division do, where
14 should their research emphasis be, what should be some of
15 the principles by which it operates. Now it was finally
16 anointed by the faculty and is up and running, although I
17 don't think our programs are quite so mature as what you
18 heard from Al.

19 A couple of comments on your questions. The
20 principal obstacle has been skepticism on the part of
21 established faculty and a reluctance to look as though
22 you are getting soft or wimpy or crazy among your friends

1 at distant sites; a big issue.

2 I can imagine some of the letters that Dr.
3 Fishman received. They were probably written by the same
4 people.

5 Expanding federal support, I think that this is
6 a place where public interest, a perception of what
7 patients and doctors are doing and an enhanced role for
8 public expression in NIH priority setting. I thought Lee
9 Rosenberg's talk was terrific.

10 A big contribution from the CAM philosophy for
11 us has been the wellness emphasis of very weak components
12 in most medical school curricula. So the emphasis on
13 wellness, starting with what patients want, the real
14 attention to symptom relief, also very weak in
15 traditional medical school curricula, and a response to
16 neglected populations, these have all been part of it.

17 I think bringing practitioners and researchers
18 together in common settings is a very important part. We
19 are doing that through meetings of our division, through
20 meetings of a center for clinical work at Beth Israel
21 Hospital and likely to be replicated at other hospitals
22 soon.

1 We have heard anecdotes disparaged. I would
2 like to point out that good, well-written anecdotes
3 should not be disparaged. Anecdotes were the first basis
4 of the field of pharmacogenetics. Clinical observations
5 of a drug doing something funny came out of clinical
6 practice. Its modern expression in the Genome Project is
7 quite another thing. But pharmacogenetics got going and
8 clinical genetics got going from perceptive
9 observations, written up well and then leading to the
10 question that the scientists in the previous panel you
11 have got to measure something and you have got to be able
12 to do something, but they can start with well-described,
13 alertly observed observations.

14 The overlap areas, we have talked a lot about
15 them. The one that hasn't been mentioned educationally
16 adequately is ambulatory medicine and education. The
17 medical schools are just getting going in the area of
18 ambulatory education. That is a place where quite
19 different attitudes about symptoms, about what really
20 bothers patients, about what commissions can do, they are
21 quite different from what happens in the acute inpatient
22 settings and it is a place where CAM could play quite a

1 role.

2 Finally, there was the point about the public
3 role in setting priorities. A lot has been said about
4 that already and I have tried not to repeat what has been
5 said before.

6 DR. GORDON: Thank you very much, Dr. Federman.

7 Actually, I had thought the difference was
8 between Quaker origins and Congregationalist origins.

9 DR. FISHMAN: There is a whole book that
10 everybody should read on Puritan Boston, Quaker
11 Philadelphia. Do you know that one?

12 DR. FEDERMAN: On the other hand, there should
13 be something to measure. One dollar was put into
14 Philadelphia and one dollar into Boston for investment
15 over the years. Boston did far better than Philadelphia.

16 [Laughter.]

17 DR. GORDON: Thank you, Dr. Federman.

18 The next speaker will be Dr. Joseph Pizzorno.

19 DR. PIZZORNO: Thank you.

20 I am going to talk about three things today:
21 first, about how Bastyr established its successful
22 research institute; second, about the problems we have

1 run into in doing natural medicine research. Finally, I
2 am going to give you five policy recommendations about
3 ways we believe that you could help make it work better.

4 So first off, in terms of Bastyr University, as
5 you know, I am the founding president of Bastyr
6 University and led the institution starting in 1978, with
7 a concept of science-based natural medicine because we
8 could see that centuries old traditions of natural
9 healing had a lot to offer, but until we brought them up
10 to modern standards of education, research and clinical
11 practice, it would never be accepted by mainstream
12 society. We have worked hard at Bastyr University to do
13 that.

14 So because of our science orientation, of
15 course, research has always been important to us. Of
16 course, there was no money for doing that. Nonetheless,
17 we started doing research in 1983 and we did that
18 basically by allocating student tuition money. Because
19 we are a tuition-driven institution, we do not have the
20 blessings of state, federal, local foundation support for
21 our institution. It all came out of student tuition.
22 But we felt it was important.

1 We invested in it. We also got some of the
2 companies in the natural products industry to support
3 research. They were primarily product oriented but at
4 least it was something to get us engaged. Since then we
5 have now developed a fairly large and I think a very
6 sophisticated natural medicine institution, a research
7 institution that has done quite a number of studies and
8 quite a few have been published in peer reviewed
9 scientific literature.

10 I believe that a key to why we have been
11 successful in doing good research that is relevant in
12 this area is because we have used cross trained
13 professionals. Dr. Leanna Standish, whom you will be
14 hearing from tomorrow, has a Ph.D. in research. She also
15 has her degree in naturopathic medicine and also a degree
16 in acupuncture.

17 Dr. Calabrese, who has done a lot of work in
18 this region was trained as a naturopathic physician and
19 went back to the University of Washington and got his
20 master's in public health and his master's thesis was
21 outcomes research in CAM.

22 So what we have done is we have drawn to the

1 institution people, who understand deeply both sides of
2 the equation. I want to stress that. While I think
3 there is value in bringing CAM professionals to work with
4 center researchers, there is also a lot of limitations in
5 that particular model.

6 So, what are some of the problems we have run
7 into? First off, exclusionary language in existing
8 legislation and rules. By the way, I will give you a
9 handout with all of my presentation on it.

10 There are three problems here. First off is a
11 lot of legislation in Congress and the rules passed by
12 various departments dealing with health care research is
13 of exclusionary nature. That means it only covers M.D.s
14 and D.O.s doing the research or those doing research in
15 medical schools.

16 As a CAM institution, there has been a
17 tremendous number of doors closed to us. Second, in
18 situations where there is nothing explicit in
19 exclusionary language, there have not been mandates so as
20 to allow de facto exclusion. While I have many medical
21 doctors, who are great friends of mine, many who are here
22 today, in many situations, that gatekeeper role is played

1 by M.D.s, who were not interested in CAM research.

2 Finally, even when allowed, it wasn't funded.
3 So the barriers have been substantial. Examples: In the
4 service area, Indian Health Services, has restrictive
5 rules that don't allow CAM practices. The National
6 Health Service Corps has exclusionary language that
7 specifically excludes natural medicine practitioners. In
8 their research, the Centers for Disease Control has no
9 mandate. The Agency for Health Care Quality and Research
10 has no mandate or funding.

11 The Health Care Financing
12 Administration/Medicare has specific exclusionary
13 language and the graduate medical education legislation
14 has exclusionary language. If you look at the Balanced
15 Budget Act of 2000, which is funding several areas of
16 health care and health care research, there is, again,
17 exclusionary language. CAM professionals and
18 institutions are specifically not included.

19 This also goes into quasi-governmental
20 agencies, such as, for example, the Howard Hughes
21 Research Institute, which has close ties to the NIH. Its
22 goals are lofty to strengthen and expand the nation's

1 pool of medically-trained researchers and so provides
2 fellowships for medical students and for young faculty to
3 be engaged in research. It is restricted to only M.D.s
4 and D.O.s.

5 So, lots of problems. I actually have a
6 several page list of all the agencies and all the
7 problems, but I think you get the idea. It is easy to
8 fix. You can do enabling legislation that simply says go
9 through all the federal legislation and remove
10 exclusionary language and replace it with inclusionary
11 language. You can make these kind of changes.

12 Next is an area which I notice has not gotten
13 much attention with the Commission that I think is very
14 important. That is that natural medicine and public
15 health are natural partners. If you look at the
16 philosophies of CAM and public health, it is remarkable
17 how similar they are.

18 Patient education, prevention, healthful
19 living, self-help, personal responsibility for health, we
20 all have the same conceptualizations. The main
21 difference is that natural medicine professionals do it
22 on a one-to-one basis; whereas, public health tends to do

1 it on population-wide areas.

2 We believe that there is tremendous opportunity
3 to engage in research that very specifically looks at how
4 to more carefully bring together natural medicine and
5 public health concepts and initiatives for the betterment
6 of public health. In Seattle, we created an initiative
7 to create an institute to do just that. I will be giving
8 you a copy of what that proposal looks like.

9 Next is a significant problem and that is if
10 you look at most of the research being done today, it is
11 isolated therapeutic research, not integrated care.
12 Natural medicine, the reason people go to natural
13 medicine practitioners is because of our completely
14 integrated personalized approach to providing health
15 care. That is not the research that is being done.

16 Most of the research being done right now is by
17 M.D.s and Ph.D.s, who have been trained in the drug
18 approach, which is fine for drugs and for agents, such as
19 dietary supplements and some herbals that fit the model.
20 But that model does not work very well.

21 There are substantial problems in trying to fit
22 natural medicine interventions into conventional,

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1 randomized, placebo-controlled trials. So, for example,
2 individualized treatments for standardized protocols,
3 combination treatments for single agents, homeopathy,
4 blinding in certain modalities; for example, contrast
5 hydrotherapy for peripheral vascular disease, how do you
6 blind that?

7 So I think you get the idea. There are lots of
8 problems. So one thing we would like to recommend is
9 that you establish a consensus conference on developing
10 research methodologies that will work for CAM.

11 I am not talking about something which is
12 different or unusual or not appropriate, but the idea is
13 to get together people who come from, for example, the
14 Institute of Medicine, senior editors of leading
15 journals, The New England of Medicine, Lancet, et cetera,
16 experienced CAM research professionals. Let's get them
17 together for a several day conference and figure out
18 methodologies that we can agree will answer the questions
19 we want to actually ask and will be of the kind of
20 quality that will be published in peer reviewed
21 scientific journals so people can hear this information.

22 Finally, we have to increase funds to academic

1 health centers. It is well documented now that funding
2 in academic health centers in conventional medicine has
3 resulted in huge advances in medicine. That is great.
4 We need to do the same thing in CAM institutions because
5 this is where the body of understanding of this medicine
6 lies. But we don't have the infrastructure and the
7 training that has to occur is basically happening with
8 very limited resources.

9 So look at CAM educational institutions where
10 you do education, research, clinical sciences and that
11 also have collaborations with conventional medical
12 institutions. Finding these institutions I think is
13 incredibly important.

14 So in summary then, my policy recommendations
15 are five:

16 No. 1, remove exclusionary language from
17 existing legislation.

18 No. 2, specifically mandate both inclusion and
19 funding of CAM research.

20 Next, establish an institute for integrated
21 CAM/public health research.

22 Third, fund research into all senses of

1 healing, not isolated therapies.

2 Fourth, fund a consensus conference on CAM
3 outcome research protocol.

4 Finally, establish a formal process for funding
5 the creation of CAM academic health centers.

6 Thank you for your attention.

7 DR. GORDON: Thank you very much. Thanks for
8 being succinct in presenting a great deal of material.

9 Dr. William Meeker.

10 DR. MEEKER: Thank you. Good morning, ladies
11 and gentlemen. I am very honored to address this
12 prestigious commission and I wish you all the best of
13 luck in your work because it is not easy work.

14 The CAM movement and the values it represents
15 are congruent with the desire for a more human-oriented
16 health care system and I think ca research as the
17 potential to help that transformation.

18 It also is interesting to note that CAM
19 research is helping the move to evidence-based health
20 care. Demands for evidence of the effectiveness of CAM
21 has actually highlighted the lack of evidence for many
22 established medical procedures and products. So

1 ironically, in some respects, CAM actually may help make
2 all of medicine more scientific.

3 In my very limited time today, I want to make
4 two major points and put them in some context for you.

5 The first one is that the professions that
6 value it the most will accomplish the best CAM research
7 because it is their professional duty. It is the
8 obligation of chiropractic, for example, to develop its
9 research capacity and conduct research in its training
10 institutions, just like all the other health professions.

11 My second point, which is a logical extension
12 is that the federal government has a duty and the
13 obligation as an agent of the public to assist the
14 development of research capacity of the CAM professions
15 just as it has for the other health care professions.

16 The chiropractic profession already has a large
17 role in health delivery in the U.S. With over 60,000
18 professionals now and growing, chiropractic is the third
19 largest doctorate health profession in the United States
20 and is by far the largest, most popular, best organized
21 and most regulated of all the CAM professions.

22 Between 11 and 15 percent of the U.S.

1 population visits a chiropractor every year. This
2 translates to almost 200 million annual patient visits to
3 chiropractors, which is about 30 percent of the total of
4 all visits to all CAM professionals.

5 Economically, this means somewhere between \$8-
6 to \$9 billion in health care expenditures. For some
7 contrast, you should know that visits to primary care
8 medical doctors is just around 400 million visits, or
9 just a little twice as much.

10 The Council on Chiropractic Education accredits
11 all the 17 U.S. chiropractic training institutions, which
12 is in turn approved by the U.S. Department of Education.
13 After years of work, the Chiropractic Health Care Section
14 is now officially part of the American Public Health
15 Association.

16 Spinal adjustments and manipulations have been
17 studied in over 70 randomized controlled trials and the
18 procedure has been approved as a treatment recommendation
19 for back pain by the Agency for Health Care Policy and
20 Research, which is now Healthcare Research and Quality.

21 Chiropractors also deliver a huge proportion of
22 all other types of CAM procedures and products. Patients

1 are a cross section of U.S. demographics and present
2 predominantly with musculoskeletal complaints.

3 Studies also show that patients are very
4 satisfied with chiropractic care and they are willing to
5 pay out of pocket for it if they have to. Thus, I would
6 submit that chiropractic is actually a mainstream health
7 practice and a considerably large one at that.

8 In fact, a well-known CAM researcher at a
9 famous medical school once told me that if we consider
10 CAM to a rom, then chiropractic is the elephant standing
11 in the middle. It simply cannot be ignored any longer.

12 For additional perspective, the implications of
13 the word "integration" must be understood as it relates
14 CAM professions, particularly chiropractic. I think
15 there is a major distinction to be made between
16 procedures and products and professions. For example,
17 chiropractic is a profession. The spinal adjustment and
18 manipulation that chiropractors use is a procedures.

19 Procedures and products in professions require
20 different forms of research. They require different
21 types of disciplines to be brought to bear. Notice that
22 effective new procedures and products are relatively easy

1 to integrate into conventional medical practice and there
2 are established pathways and a history of doing that.
3 That process, which is rarely as scientific as we would
4 like to think, does define the progress of medical
5 innovation.

6 On the other hand, it is an entirely different
7 thing to integrate professions, especially health
8 professions that have historically been at some odds.
9 Although integration already occurs at the health
10 consumer level, because patients choose and integrate the
11 health care they want within the limits of convenience
12 and cost, it is not happening on any large scale at the
13 doctor-to-doctor level, at least not yet.

14 So the conclusion is this. If true CAM and
15 conventional medicine integration is what we want and is
16 supposed to be the end result of CAM research, then the
17 research agenda must be very broad and deep. Indeed, it
18 must be interdisciplinary, multiple disciplinary and
19 interprofessional. Social, as well as clinical and basic
20 sciences must be used.

21 These attributes need to be elaborated
22 explicitly in all federal policies designed to facilitate

1 CAM research. To reiterate my first point now, the best
2 CAM research will arise from the professionals that are
3 most interested in it and from their institutions, but
4 those professions need help, just like the other health
5 professions.

6 Let me be very clear here. The primary
7 responsibility for chiropractic research lies squarely on
8 the shoulders of the chiropractic profession. It is not
9 a choice that we have. It is a professional obligation
10 and a duty. We accept this and the chiropractic and CAM
11 professions must develop their own inquisitive research
12 cultures and in so doing, they must continually strive to
13 not prove, but to improve their practices.

14 So if you believe as I do that research is a
15 profession's ultimate responsibility and if you believe
16 as I do that the best quality research will arise from
17 the profession that values it the most, then I hope you
18 will logically agree to my second point, which is that
19 the federal government, which represents the will of the
20 public, can and should assist the CAM professions and
21 institutions in every possible way to develop their
22 capacity to engage in high quality research and

1 education.

2 The government has many powerful ways to do
3 this and all of them should be brought to bear, just as
4 they have developed the research capacities of all the
5 other health care professions.

6 Chiropractic does not have an adequate research
7 infrastructure. Chiropractic is not plugged into the
8 standard research bureaucracy of the federal level.
9 Federal funding for research institutions began only six
10 years ago, with a program established at the Health
11 Resources and Services Administration. This has amounted
12 to approximately \$350,000 per year. Not a lot of money.

13 In 1997, only three years ago, the NIH Office
14 of Alternative Medicine awarded a five year center grant
15 of \$2.7 million to the Palmer Center of Chiropractic
16 Research, which I head. I am very grateful for this
17 unprecedented support, but it is not much money,
18 considering the size and impact of our profession of
19 chiropractic.

20 Our institutions are still tuition dependent
21 and we are used to that, but, needless to say, resources
22 for research are meager and what advances have been made

1 are poor bootstrap labors of love. There is an active
2 scholarly community and peer reviewed and indexed
3 journals in chiropractic, but the efforts needs to be
4 much bigger and more productive.

5 Barriers to a larger research capacity in
6 chiropractic, and I dare say the other CAM professions as
7 well, include the aforementioned isolation from the wider
8 health care and scientific communities, ignorance on the
9 part of non-chiropractic health scientists, the lack of
10 scientific career training, mentorship and job
11 opportunities for CAM scientists and particularly the
12 lack of chiropractic representation in research policy
13 making and political circles.

14 To give just one very interesting example, it
15 may surprise you to know that there is just one person,
16 one single individual only working in the entire federal
17 research bureaucracy who has chiropractic training. This
18 has just happened in the past year.

19 Only in the past two years have just a small
20 handful of chiropractors been appointed to ad hoc roles
21 on NIH study sections. To give another example from the
22 private sector, the very authoritative Pew Health

1 Commission's fourth report, entitled, "Recreating Health
2 Professional Practice for a New Century," never once uses
3 the word "chiropractic," even though it alludes to CAM
4 and recommends that health education programs require
5 interdisciplinary competence in their students.

6 Chiropractors are not tracked as part of HRSA's
7 health care work force projections. I do acknowledge
8 that the National Council on Complementary and
9 Alternative Medicine now has two chiropractors on its
10 council. I am grateful for the support that I have
11 gotten through that particular center. But it is just
12 not enough. It is not nearly enough for what we need
13 down the road.

14 So, what can be done? I am going to give you a
15 list of things that are beginnings, I think. This is
16 most important.

17 No. 1, train CAM scientists. Provide programs,
18 incentives, pre and post-doc positions and career tracks
19 for capable and interested young people.

20 No. 2, create ways to encourage
21 interdisciplinary, multidisciplinary and inter-
22 professional collaborations between CAM institutions and

1 tax-supported universities.

2 No. 3, apply the entire universe of research
3 project and program funding mechanisms to initiate,
4 encourage and support chiropractic and CAM research,
5 including bricks and mortar.

6 No. 4, call for interdisciplinary conferences
7 to explore scientific states of the art on CAM topics and
8 establish rigorous research agendas. Support the agendas
9 with targeted research funding program announcements.

10 No. 5, encourage the National Library of
11 Medicine to include CAM topics and references in its
12 indexing systems.

13 No. 6, to establish academic CAM clinical
14 centers.

15 No. 7, support CAM training institutions in the
16 broadest possible sense, like all other health
17 professions in order to eliminate the dependence on
18 tuition and provide the resources to develop a more
19 effective and consistent research culture.

20 No. 8, ensure that chiropractors and other CAM
21 professionals are routinely appointed and otherwise
22 included in research policy making efforts. This would

1 include the hiring of chiropractors at the same level as
2 other doctors in the Department of Health and Human
3 Services, as administrators and investigators.

4 Finally, consider that CAM professions and
5 their institutions could benefit from special attention
6 in order to jump start their research efforts; perhaps
7 something similar to the Centers of Excellence program in
8 HRSA's Bureau of Health Professions.

9 In summary, I want to thank the organizers once
10 again. CAM professions as distinct from CAM procedures
11 and products will, if supported properly and fairly,
12 eventually produce the best quality CAM research. I
13 think the full financial force and creative power of the
14 government and should be brought to bear in this way.

15 Thanks very much.

16 DR. GORDON: Thank you very much. Thank you
17 all four. These are wonderful examples and really
18 heartening examples of the way, from very different
19 perspectives, the agenda of a more comprehensive approach
20 to medicine is being advanced.

21 I have a couple of announcements and then we
22 will begin with questions.

1 First, this is a very important announcement.
2 Lunch for the Commission members will be in Room 634F and
3 the news briefing is going to be in Room 405A, shortly
4 after this meeting when the morning session concludes.
5 So we will conclude here at 12:15, and lunch will be
6 immediately following for Commission members, and the
7 news briefing will begin promptly at 12:30 in 405A.

8 Also, if commissioners could bring Tab 6, not
9 just the tab but the material behind Tab 6 to lunch, that
10 would be helpful.

11 Tom.

12 MR. CHAPPELL: Thank you for all of you being
13 here and presenting your experiences.

14 I have been paying attention to how innovation
15 happens in each of your situations. I see some
16 interesting ways that are evolving. I guess I am aware
17 that we all are dealing with a consumer-initiated and
18 -driven reality. I am aware that there is a champion-led
19 approach to this. However we call that champion, each of
20 you has decided how that champion model works in each of
21 your situations.

22 It has been sponsored by the highest authority

1 within your systems, so that there is permission for this
2 to happen and it is supported and resolved by
3 professionally integrated collaborations and sufficient
4 resources. Each of you, though, has had a different way
5 of applying those principles.

6 I guess, Dr. Federman, I am interested in the
7 champion model at Harvard in this case. To what extent
8 did the sponsorship of this by your level need to
9 continue to assert the protection from the gatekeepers
10 that you were speaking about? At what point in the
11 evolution of the process did you integrate versus the
12 point at which you kept the project separate?

13 DR. FEDERMAN: I was asked by the dean to bring
14 it into the mainstream of the school so that all of the
15 school's strictures about how to organize a division, et
16 cetera, were met and that it had a high level champion to
17 get it established. It would not probably have reached
18 that point without the dean's office intervening.

19 I am likely to spend, as I projected, about
20 another year or two in this same capacity but a
21 diminishing role as the other hospitals join in
22 establishing centers as a common seminar program,

1 continuing medical education course and approach to
2 credentialing practitioners, which is much further along
3 at Penn than we are. But we see kind of benchmarks,
4 which would both be accomplishments and clues that I
5 would do less. But it did take a dean's office
6 sponsorship and someone with an external credibility, not
7 a practitioner, not an advocate. In that sense, rather
8 similar to what Dr. Fishman was asked to do.

9 So I picture it will be about three years of
10 work on my part to bring something that was well along
11 into an official and then autonomous status.

12 Does that answer your question?

13 MR. CHAPPELL: Yes. Thank you.

14 DR. GORDON: Dean.

15 DR. ORNISH: Yes, I first just want to say how
16 inspiring it was for me to listen to all of you and
17 particularly hearing what Drs. Federman and Fishman have
18 been able to accomplish in their respective institutions,
19 which I know are not always the most open to change.

20 DR. FEDERMAN: Just ask your question, please.

21 [Laughter.]

22 DR. ORNISH: My question is since you brought

1 in an opposition from various sources, did you win them
2 over or did you overrule them? What was that process?

3 DR. FISHMAN: We didn't even engage in the
4 battle. It was very interesting. I told you about how
5 the working group met and then by the normal process of
6 creating a department, we did nothing out of line with
7 the way you create a department or an institute or a
8 program or anything else.

9 When we presented it, we had opposition, but
10 none of it voiced. We would sit around the table like
11 this. I knew there were faculty members there who wanted
12 no part of us. On the other hand, the group as a whole
13 listened to reasonable discussion and were impressed by
14 the fact that our procedures as so-called scientific
15 medicine made it possible to do research, that it was not
16 unconventional. We could examine everything the way they
17 were accustomed to and even the basic scientists, we had
18 no formal opposition and I think, for example, I talked
19 to Wayne. He sat at the retreat we had.

20 The discussion was constructive. People voiced
21 reservations. The head of the Institute of Medicine
22 raised questions. June Osbourne raised questions but

1 none of it became antagonistic. It was a surprising
2 experience.

3 DR. FEDERMAN: Poetry is said to require the
4 willing suspension of disbelief. We have achieved, I
5 would say, the reluctant or unwilling suspension as the
6 level of welcome.

7 [Laughter.]

8 DR. GORDON: Thank you both.

9 Yes, Tieraona.

10 DR. LOW DOG: I have two questions. One was
11 for either of the two gentlemen here.

12 You know, complementary medicine, we talk about
13 it as if it is sort of a single entity, but it is really
14 many, many different modalities. Some institutions are
15 very reputable and have some evidence behind them and
16 some are fairly borderline. I just wondered how you
17 approached what you are bringing into your institution.

18 DR. FEDERMAN: The organization of Harvard is
19 useful in this regard because the clinical practice is
20 entirely based in the hospitals and both regulated and
21 planned there with the medical school having no role in
22 that. So we are not involved in the credentialing of

1 practitioners. We are not involved in proving the
2 pharmacopoeia at any hospital.

3 We are not involved in what clinical care the
4 patients can get. So each of the hospitals is making
5 those approvals independently. The research agenda, the
6 IRB status, the acquisition of funding to support
7 research, that will be in the division and under the
8 medical school. Then project by project review will be
9 the way in which the delimiting of the effort will be
10 achieved.

11 DR. FISHMAN: We take in a more deliberate
12 approach. Remember what I said is we have not resorted
13 to any unconventional way of introducing a new therapy
14 into our health system.

15 We found that we could keep the same way a
16 departmental chairman says he or she would like to have
17 acupuncture. Great. The chairman has never heard of
18 acupuncture. He goes to the steering committee. He
19 includes people who know. The steering committee
20 evaluates what you have to do, et cetera, et cetera. He
21 goes back. The chairman says to the applicant, this is
22 what you have to show me. Where did you get your

1 approval? How much experience have you had, et cetera.
2 Then it is transmitted right up to the board of trustees
3 in the usual way.

4 I have outlined in the back over here, two
5 appendices. We did this for acupuncture with a very
6 deliberate detail, every step in the process for
7 credentialing. Massage therapy, the same thing. We have
8 just done this for yoga and for tai chi the same way and
9 we have introduced it into our clinics.

10 DR. LOW DOG: That is great. See if we can
11 bring that back to New Mexico.

12 Dr. Pizzorno, I want to commend Bastyr for all
13 of the work that it has really put forward. I wanted to
14 know how much interface do you have with the medical
15 school up in Seattle. Is there a lot of collaboration
16 going on? Have you found that a friendly environment?
17 Are we doing a lot of research collaboration, residents
18 coming over, sharing med students? I mean, how open has
19 the community been in seattle for your school?

20 DR. PIZZORNO: You ask a very good question and
21 the committee in general has been very receptive. The
22 medical school has not. However, I have to say that is

1 changing and I think it is changing for several reasons.
2 One is because so many faculty and students at the
3 University of Washington Medical School want to be
4 engaged with us.

5 I have been giving a lecture on alternative
6 medicine there for the last 15 years, I guess. At the
7 last meeting, I had about a dozen medical students come
8 up to me and ask how they could take courses at Bastyr.
9 So there is a lot of pressure building from within.
10 Second, the research committee there now has become
11 receptive and Dr. Standish will be talking tomorrow about
12 now we actually have some collaborative studies with the
13 University of Washington.

14 In addition, Children's Hospital, which is a
15 part of the University of Washington Medical School
16 system approached us and we now provide natural medicine
17 services for children at Children's Hospital. So that
18 door is finally opening and I expect that there will be
19 some pretty exciting things over the next several years.

20 DR. GORDON: Thank you.

21 Wayne and then Bill Fair and then George.

22 DR. JONAS: Thank you.

1 Thank you very much for your statements, all of
2 you. I am impressed by the amazing commonalities and the
3 amazing contrasts between two of the most exemplar
4 conventional research academic training and two of the
5 most exemplar unconventional, if I can use that term,
6 research institutes.

7 The commonalities really are dialogue and
8 training and dual types of education from what I hear.
9 Those are things that everyone talks about, everyone
10 needs and I think it clearly means that there needs to be
11 education all around. There needs to be training all
12 around in terms of research, especially, but other areas
13 also.

14 The contrast is also, I think, equally clear
15 and in terms of groups that have really the
16 infrastructure necessary to do the kind of research that
17 we all hope can be done here and those that feel like
18 they haven't got the dollar yet and so haven't been able
19 to really see it grow and invest over hundreds of years
20 really.

21 So I am wondering if there could be perhaps a
22 higher level dialogue since the dialogue in education is

1 going on. I would be very interested to hear from you
2 all if that has occurred or if there has been discussion
3 of whether at an inner institutional level there could be
4 a discussion about a dialogue and kind of mutual types of
5 educational projects that have occurred at that level,
6 rather than simply at departments bringing in
7 practitioners or universities wanting to get more
8 training people into the federal government, for example?

9 Any comments on that? Has that occurred or
10 would that be possible to occur?

11 DR. MEEKER: Good question, Wayne. I think
12 that --

13 DR. JONAS: I am sorry. Let me just say,
14 again, thinking about it, is there anything that we as a
15 council, thinking about federal regulations might be able
16 to encourage that in some way to support you all on that,
17 if there are successful or some interest?

18 DR. MEEKER: The simplest and easiest thing
19 would be to encourage that dialogue by some sort of a
20 conference or workshop where that would be the specific
21 topic, I think, as a starting step. But we have a number
22 of relationships with the University of Iowa Medical

1 School and Department of Bioengineering and the
2 Department of Neuroscience.

3 The point I am trying to make, though, is that
4 all of these are rather entrepreneurial, individual-to-
5 individual relationships that have built up over common
6 research interests and also educational interests. There
7 has not been any top down rational approach to this. It
8 has been more like the Harvard approach. It has been
9 people getting together a lot by chance, a lot by just
10 outreach. They found an area of commonality. They like
11 each other. They start communicating. They realize they
12 can work together. They propose something. They develop
13 it from the ground up.

14 That is, I think, the way most things work. It
15 would be nice to have something coming from the other
16 side and have them meet in the middle. That has not
17 happened very much yet.

18 DR. FISHMAN: Could I make a comment on that?

19 Wayne, Dan and I have been talking about this
20 also. I think that the center at the NIH has done a
21 great job in tackling the present situation. It has
22 created centers. There are ways by which the centers can

1 communicate. We took the tact that we would have to take
2 the same pathway that I saw at the NIH when I was growing
3 up in the Heart, Lung, Blood Institute. We would have to
4 train young people, include it in the educational
5 program. So we never applied for any funding from
6 anybody. There was no source of it. What we did within
7 the institution is we teamed up with the Center for
8 Epidemiology and biostatistics, found they had a couple
9 of empty training slots.

10 We stole a couple of training slots from some
11 other people, got people the same way we began with the
12 Heart, Lung, Blood, to start from below and work our way
13 up. I think the time will come when there should be a
14 meeting of people at universities, who want to exchange
15 ideas. This is a tactic that is very good. We had a
16 national registry on pulmonary hypertension where
17 everybody was doing their own thing, brought them
18 together in the project and suddenly they were talking
19 with each other. They were investigating.

20 So I am not sure we at that stage yet, but I
21 think it is a definite stage to aspire to.

22 DR. GORDON: Thank you.

1 Joe, go ahead.

2 DR. PIZZORNO: I think it is critical. There
3 has got to be close collaboration between the natural
4 medicine institutions and the conventional medicine
5 institutions.

6 As you may know, we just took a huge step in
7 this direction and actually appointed a medical doctor as
8 our academic dean, who was the associate dean at the
9 University of Washington School of Medicine and having
10 run them on campus a few months ago has had a huge impact
11 on helping to open that door at the University of
12 Washington, School of Medicine. It needs to happen and I
13 think a way that you could facilitate that would be, I
14 hate to say this, but a lot of these things fall to money
15 and if you could provide a grant or something for these
16 kinds of collaborations, I suspect you would see more
17 happening.

18 DR. GORDON: Actually, we don't hate to say it,
19 we very much appreciate your saying it. That is exactly
20 what we are looking for from all of you and everybody who
21 will be sitting at the table and people in public
22 comment. Our mandate is to recommend legislation and

1 legislation comes with appropriation most of the time.

2 So please tell us if you thoughts about how we
3 should be recommending the money be spent. So, thank
4 you.

5 Bill.

6 DR. FAIR: Yes. I, too, found the panel very
7 informative.

8 I wanted to ask Dr. Meeker, who gave a nice
9 overview of the barriers, if you will, to acceptance of
10 chiropractic nationally, particularly in the research
11 area, on a smaller scale, what do you do at your
12 institution to introduce students to research methodology
13 because it seems to me that is where you have to start.
14 You know, you just can't say up here we want chiropractic
15 research. You have to go back to where you are and say
16 we know how to do good research and then work for the
17 others, get the funding from a higher level.

18 DR. MEEKER: A very good point. We train
19 students basically as consumers of scientific
20 information, not necessarily the creators of it. We hope
21 that practitioners will be able to read peer reviewed
22 journals, be able to extract what is relevant to their

1 practice, change what they do for the better and to keep
2 up with the field in that way.

3 We don't necessarily expect the average
4 chiropractor to be able to conduct any sorts of
5 experimental research, other than perhaps to do well done
6 anecdotal case studies and have them published. We do
7 not have the capability currently because of resources to
8 develop a separate track of more directed research
9 training, although we are working on ways to do that, do
10 some mechanisms that we hope may be funded by NCAM.

11 I agree with you. This is a very important
12 aspect. I personally wish we could do more. We have the
13 same problem, I might add, with our faculty. Most
14 chiropractic faculty members do not engage in research.
15 We have to go out and hire people with D.C. degrees and
16 Ph.D.s in various areas. Those are our most productive
17 faculty members because they have been apprentice to the
18 scientific process.

19 This, I think, is our biggest need. We need
20 ways, training programs and career tracks, so that people
21 that have a natural inclination in this direction see
22 that they can have a job and a career doing it. That has

1 not existed in the CAM profession so far. It has been
2 very bootstrapped.

3 DR. GORDON: Thank you.

4 George and Joe and then we are going to break
5 for --

6 DR. PIZZORNO: Can I respond to that question
7 also?

8 We fully agree we need to train the students
9 and the same as Dr. Meeker, we train the students in the
10 understanding of scientific method, but also as an
11 accredited institution, we always go for work study
12 monies. So we have had a huge number of students use
13 work study monies to actually work in research with the
14 practitioners and Ph.D.s doing the research.

15 In addition, for several years now, we have had
16 a Ph.D. program in CAM research on the drawing board, but
17 have not been able to find the funding to bring it
18 forward. We actually like to create researchers within
19 the CAM institution that have that deep understanding of
20 what our philosophy is about, but also how to apply
21 scientific methods to that.

22 DR. GORDON: Thank you.

1 Dr. Federman.

2 DR. FEDERMAN: I support the idea of a
3 consensus conference, both the preparation for it and the
4 publicity of the outcome.

5 DR. GORDON: Could you turn on your microphone,
6 too. Your voice is clear but I think it will help with
7 the recording.

8 DR. FEDERMAN: I support the idea of a
9 consensus conference. I think both preparing for it and
10 reporting it could have a good stimulating impact.

11 But another one, legislation may be a little
12 heavy handed for this, but if the new center for CAM and
13 other NIH institutes proposed granting programs
14 cooperatively, that might be a way to connect CAM with
15 existing institutional strengths. The NIH is sometimes
16 criticized for the relative autonomy of its institutes,
17 but a collaboration between CAM and the new center and
18 some of the other institutes with funding specifically of
19 interdisciplinary research might be something to
20 recommend.

21 DR. GORDON: Great. Thank you.

22 Dr. Fishman.

1 DR. FISHMAN: I think there is an easy solution
2 for that, truthfully. I approached the school of
3 chiropractic in Philadelphia about doing a project on low
4 back pain. We had some discussions, but after awhile
5 there wasn't enough research interest, although the
6 school had a wonderful population of patients and
7 physicians and we could match it in our Department of
8 Rehab medicine. We could never get off the ground.

9 So I think that fundamentally the research
10 orientation isn't there and if one could promote that by
11 partnering, because I really believe that with the
12 experience of a school of chiropractic, doing it right
13 the way they think and a school that is doing it the
14 other way, we could really get something solved in a
15 rather remarkable way by just measuring the outcome, you
16 see. That just hasn't been done.

17 DR. GORDON: Thank you very much.

18 George.

19 DR. BERNIER: Dan, I would like to pursue a
20 little bit the medical student education component. You,
21 obviously, had a long and rich history of problems
22 learning the new pathway. Did that facilitate the

1 introduction of CAM literature and studies into the
2 student curriculum or was it all done in the third year?

3 DR. FEDERMAN: The question is what has our
4 experience been with introducing CAM-related material in
5 the first two years. That is one of the advantages of
6 our current structure. Through the dean's office,, we
7 have more control over the individual courses than used
8 to be true. So we have been able to give them a mandate
9 to bring more of that information from other disciplines
10 as well, aging and ethnics and substance dependence, into
11 the first two years and, yes, that has started to work.

12 We have more experience with this now than
13 before. Previously, it was strictly in the third year.
14 It has moved into the tutorial experience of the first
15 one.

16 DR. GORDON: Okay.

17 Joe.

18 DR. FINS: As a follow-up question that is
19 about process, could you address what you think are the
20 substantive core components of an undergraduate medical
21 curriculum in this? If you don't have an answer to
22 that,, is there a way that we could ascertain that so

1 that perhaps down the road we could set standards.

2 DR. GORDON: Joe, we can bring them back for a
3 much more extended discussion when it comes time for
4 education. That might serve us better, rather than
5 trying to answer it. You are welcome to answer it real
6 briefly.

7 DR. FISHMAN: I can tell you the best answer I
8 know is that we have just put together an education grant
9 to the NIH, which provides in great detail where it comes
10 in year one, year two, year three, postgraduate,
11 Internet, on the web, et cetera.

12 So that is available.

13 DR. GORDON: Great.

14 Bill, you had a brief question.

15 DR. FAIR: This can be answered "yes" or "no"
16 by the panelists.

17 Do we need a program similar to what I perceive
18 as extremely successful M.D., Ph.D programs in medical
19 colleges? Do we need programs that would direct training
20 M.D. with chiropractic or whatever?

21 DR. FEDERMAN: Yes.

22 DR. MEEKER: Absolutely yes.

1 DR. FISHMAN: No. If you will accept the
2 premise that I think that we are all hearing, that we are
3 doing scientific approach in research. We have got the
4 machinery set up. There is no reason why somebody who
5 wants to get a Ph.D. in some aspect of what we are now
6 calling complementary, that will become conventional
7 medicine once it has been proved. Then they can go
8 through. Or else it is a research question. So it is a
9 question of finding a mentor. Who is going to teach you?
10 What courses do you have to take? Who will measure what
11 you are doing?

12 So the machinery exists in all of the research
13 institutions that I know.

14 DR. FAIR: Well, the M.D., Ph.D. program
15 provides an incentive and the funding for both the
16 student and the institution.

17 DR. GORDON: So we have a no because you don't
18 think it is going to be necessary because things are
19 going to come together and we have three yeses. Is that
20 right?

21 DR. FISHMAN: I would just say one thing. Put
22 more money into the M.D., Ph.D. program, which allows for

1 this and encourages it. There is also the Duke program
2 has just sponsored a year out program. The Sarnoff [ph]
3 program is available. Any dean's office has a whole list
4 of opportunities if you find a mentor, if there is a good
5 question and you get the support for it.

6 DR. GORDON: Yes.

7 DR. MEEKER: I have to say what this question
8 comes down to, because of the "yesses" and "noes," really
9 is, who is going to get to control this particular aspect
10 of research. Really, it is.

11 If you believe that the best research is going
12 to come from the professions that value it the most, and
13 I am not talking a product, a pill. I am not talking
14 about some kind of procedure. I am talking about
15 professions. Then the answer has to be, unquestionably,
16 yes, we have to do this sort of thing. These things do
17 not exist in naturopathy. They do not exist in
18 chiropractic. They do not exist in oriental medicine.

19 Now, the question you want to ask yourselves
20 is, do you think they should?

21 DR. GORDON: Any other last words from
22 panelists about this?

1 [No response.]

2 DR. GORDON: Thank you very much. This has
3 been a great discussion. We look forward to seeing at
4 least some of you again as we continue. Thanks very
5 much. Thank you, for the commissioners.

6 We will be meeting back here at 1:30 promptly.

7 [Lunch recess taken at 12:15 p.m.]

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A F T E R N O O N S E S S I O N

[1:35 p.m.]

Public Comment

DR. GORDON: We are going to begin with public comment now. This is a very important part of the work that we do, and in each session of the full commission that we have here in Washington, we set aside two hours, or close to two hours, for public comment.

In the town hall meetings around the country, those are meetings that are completely meetings, in a sense, of public comment. So we welcome you to come, and we welcome you to come back.

What we are going to do here is, in this instance where people are addressing very different issues, we will give each person three minutes and then we will have time for the Commissioners to ask questions of that person, rather than go with a full panel of people.

So we will begin with Thomas Glonek of the American Academy of Osteopathy. He is first on our list.

[Pause.]

DR. GORDON: He is not here. Let me just see

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1 if the people who signed up are here. Susan Scurlock-
2 Durana, is she here?

3 Oh, good. Would you like begin then?

4 MS. SCURLOCK-DURANA: Actually, I am here today
5 on the part of Dr. John Upledger, with the Upledger
6 Institute, because he is out of the country at the moment
7 and we received word that you were doing this and he felt
8 like it was important for me to bring a couple of issues
9 to the forefront.

10 The main one that he wanted me to address was
11 the question you were asking about how can we more
12 effectively integrate the CAM and conventional research
13 communities to stimulate and coordinate research. He has
14 asked me to speak to that because part of what we are
15 looking at in terms of complementary and alternative
16 medicine has to do with hands-on therapies and double-
17 blind studies with those kinds of therapies are
18 relatively useless because you can't get the placebo
19 effect out of the intervention and you can't really
20 reduce the variables to one specific thing.

21 In that process then, what his point was for me
22 to make today is that we really need to take a different

1 look at the kinds of scientific research that we are
2 allowing with these kinds of therapies as objective and
3 valid research, but research that is not necessary
4 traditionally been looked at scientifically.

5 In particular, he asked me to come and talk
6 about the Vietnam veterans project that they have just
7 completed in the last year, where they worked with 22
8 veterans and worked with a whole complement of things
9 that were in terms of different kinds of therapies and
10 hands-on therapy, primarily being craniosacral therapy,
11 but that they got tremendous results and looking at
12 outcomes as opposed to looking at variables. He feels
13 like it is very, very important.

14 I have that research available here if you all
15 would be interested in it. That is primarily what he
16 wanted me to say.

17 DR. GORDON: The answer is "yes." I know
18 something about the research personally. I am very
19 interested. It is the kind of research that I believe we
20 as a commission are interested in as well.

21 Are there questions from other Commissioners
22 about either the issue of hands-on research or outcomes

1 research? Yes, Joe.

2 DR. FINS: Just a quick question about funding
3 and who supports your research.

4 MS. SCURLOCK-DURANA: In terms of where we are
5 getting funding?

6 DR. FINS: That is right. Has it been a
7 problem?

8 MS. SCURLOCK-DURANA: Yes, it has been a
9 problem. They are actually in the process of looking for
10 it at the moment. Due to the fact that I am here on less
11 than 24 hours notice, I don't know what the current
12 status is on it, but I do know that the cost for a two-
13 week intensive program, which they ran five of in the
14 last 18 months, I want to say, was about \$10,000 total
15 per veteran for the entire program.

16 They got tremendous, significant results with
17 the reduction of symptoms and stability, and coming down
18 off of the whole myriad of drugs that they were on to
19 keep things under control. I have that information
20 available, but that is about the cost. So you are
21 talking about \$240,000 if you were to run a full cadre of
22 programs for 24 vets. They are used to doing somewhere

1 in the neighborhood of 8 to 10 veterans per program when
2 they do it.

3 DR. GORDON: Great. Thank you.

4 At some point, when it comes to talking about
5 services, you might want to present some of the data to
6 us from that.

7 MS. SCURLOCK-DURANA: Okay. When will that be,
8 Jim?

9 DR. GORDON: That will be December 4th and 5th.

10 MS. SCURLOCK-DURANA: Okay. I will contact Dr.
11 John about that.

12 DR. GORDON: Other questions? Anyone else?

13 [No response.]

14 DR. GORDON: Thank you very much.

15 Next is Phillip Shinnick from the Research
16 Institute of Global Physiology.

17 MR. SHINNICK: Thank you, Dr. Gordon.

18 I come here as both a research scientist and as
19 an Olympic athlete and I come here to the Commission to
20 make the Commission aware of a tremendous social problem
21 in America and to make sure that the Executive Order
22 13147 is applied to one of the largest areas of American

1 culture today.

2 I am the director of the Research Institute of
3 Global Physiology. It is a privately endowed research
4 institute. Right now we are sponsoring research in
5 QiGong for tumors and liver. We are doing things having
6 to do with acupuncture for the effects on organs. But I
7 am also a U.S. Olympian. I was captain of the U.S.
8 National team.

9 I also was an athletic director and director of
10 sports science at Rutgers. I have been in health for
11 about 20 years. The reason that I sit here before you
12 today is I was an Olympic athlete. I was former world
13 record holder in the long jump. Dr. Rosenberg said, good
14 science makes good health. Well, science has created a
15 crisis in sports that underlines the development of the
16 whole personality in health.

17 So, before, what you could do is through
18 discipline and mind techniques, through hard training,
19 through diet, you could excel in sports. Now, science
20 has brought performance enhancing drug anabolic steroids,
21 restorative drugs, where it short circuits culture and it
22 short circuits the whole process of sports. Also,

1 because sport at the higher levels is used as a model.
2 It gives a model for all of America that they can do
3 these things and short circuit the most historical
4 things.

5 In 1968, one of my good friends, who is a
6 physician, a decathlon person, he told me just before he
7 died of AIDS that he was the person who gave out anabolic
8 steroids to the United States Olympic team in 1968. This
9 is the biggest hidden secret in America today. However,
10 the reason that I am here is because I didn't want to be
11 involved in this process at all.

12 So I started to develop techniques where I
13 didn't have to take drugs. I started doing yoga. I
14 started doing breathing, doing biofeedback and I was
15 successfully able to compete at the World Class level in
16 multiple events.

17 So I think that it is a sham that everyone says
18 that anabolic steroids is the only way to go, but it is a
19 popular belief among young children. So I think that
20 there is a tremendous opportunity here for this
21 Commission to bring these things to the public, yoga,
22 breathing, biofeedback, visualization tai chi, Gong Fu,

1 Qi Gong, acupuncture, herbs, homeopathy, things that
2 don't have bad serious effects.

3 I think that there is a lot of work in terms of
4 these four points of the Executive Order. I am willing
5 in the future Commission meetings to bring forth people
6 like, for example, Gene Upshaw from the National Football
7 League Players Association, who has come to me and talked
8 to me about the necessity to train good practitioners in
9 alternative medicine for sports.

10 There is a tremendous need in this area and I
11 think this area should be developed and I represent a
12 whole cadre. I am on an international Olympic committee.
13 I am in sports medicine. I have treated over 50,000
14 people over the last 20 years. I treat the New York City
15 Ballet, all sorts of Olympic champions.

16 So I really urge the committee to look into
17 this area and develop a comprehensive plan for the
18 development of a healthy sport for our youth and for the
19 citizens of the United States.

20 DR. GORDON: I am very grateful that you came.
21 At first, when you first got in touch, I was wondering
22 now what is he going to come and talk about. Now, I know

1 and it is wonderful.

2 I think the question I have for you and you
3 made one recommendation, which I think is very helpful in
4 terms of asking Gene Upshaw to come and maybe talk about
5 professional education from the athlete's side. I am
6 wondering if there any other specific suggestions that
7 you have about areas that we ought to be paying more
8 attention to or ways we ought to approach the general
9 area of the use of CAM therapies.

10 MR. SHINNICK: Well, it is not my favorite area
11 because I really feel that sports can be done without any
12 drugs, just fresh air and health and meditation. But I
13 do believe that there are a lot of supplements out there
14 for our young people and they don't know this from that
15 and a lot of people are getting caught in these
16 international meets because they take a dietary
17 supplement available and all of the sudden they test
18 positive for anabolic steroids. I think it is a
19 tremendous problem here in terms of making evaluation of
20 the herbs and supplements available.

21 I mean, that is an excellent area. A second
22 area, of course, is the area of meditation, of these mind

1 body things, where the total personality comes together
2 and you can find that a lot of the injuries and things
3 that have to do, fears, anxieties, things that all of us
4 as personalities have, that could be tremendously
5 beneficial. You know, so, there is that area. There is
6 a tremendous amount of research here.

7 Point No. 4, we have to unify some of the
8 practitioners. There are things in acupuncture developed
9 over the last 20 years that aren't even available to a
10 lot of the acupuncturists because they are being trained
11 in the traditional medicine, sympathetic blocks, for
12 example, dry needling techniques, I mean, trigger point
13 techniques.

14 Gene Upshaw and I talked about we have to have
15 some sort of uniformity in the practitioners that come to
16 these athletes, too. We were talking about maybe setting
17 up some sort of institute in coordination with the
18 National Institutes of Health and with alternative
19 medicine, where we do national conferences on
20 practitioners for sports medicine alternatives.

21 You can see from the Executive Order there are
22 tremendous things to be done that could be applied to

1 this area and it would bring a lot of satisfaction to a
2 lot of people. It is very necessary at this time in our
3 culture.

4 DR. GORDON: Thank you.

5 Are there questions? Yes, Effie and then Bill.

6 DR. CHOW: Phil, thank you very much for your
7 enlightening remarks. The children and athletes are very
8 important. We are also concerned with overall the
9 children. From what you are saying, do you think it
10 would be helpful for all children to have type of
11 training like this?

12 MR. SHINNICK: Well, for example, yoga, in
13 joint turning, prevention of injuries, of the whole
14 concept of Qi Gong, where you do a series of mind-body
15 things and all of the sudden you have an energy and a
16 strength that you never had before. I mean, these are
17 wonderful things.

18 You go to China. You see them being practiced
19 in the streets. I mean, we are sorely in need of a
20 physical culture that promotes health and doesn't lead
21 towards a quick fix. You know, in the old days we used
22 to do sports, sunrise, sunset and birth, death and

1 harvest. This was a great celebration. We have been cut
2 off from the past. The five nations of the Iroquois were
3 the most healthy people. They had the great sports.
4 William Penn wrestled during the treaty of Pennsylvania
5 with the five nations of the Iroquois.

6 So, sports has always had a wonderful role in a
7 healthy society. Now with commercialization and anabolic
8 steroids, I really think we are at a tremendous junction.
9 I feel this commission can really do a tremendous service
10 for our society by coming on very strongly to things that
11 just don't have any bad effects on the people.

12 DR. GORDON: Thank you.

13 Bill Fair.

14 DR. FAIR: I think that is really enlightening
15 to me. I had no idea that these things could substitute
16 for anabolic steroids. I have noticed that the long
17 jumps and the New York Ballet have improved over the last
18 ten years.

19 [Laughter.]

20 Jim, this seems like such an important thing
21 and especially if we can enlist the Gene Upshaws of the
22 world, sport figures, to get this message across. My

1 question is are there other people like you around the
2 country that we could enlist, say, at town meetings
3 because this is a totally different approach than what we
4 have been talking about before in terms of preventing
5 disease.

6 MR. SHINNICK: I would be willing to help
7 organize this. I mean, I have been a spokesman for the
8 athletic movement for 25 years, you know, as a former
9 athletic director and director of sports science, that
10 the reason I sit here today is I didn't want that and
11 negate the negation. I knew what existed. I didn't want
12 it. At that time, in the 1970s, none of this stuff
13 existed. So 20 years later we are sitting here and we
14 have a great opportunity.

15 I love to talk about the divisualization, but I
16 can tell you that if you start to practice some of these
17 mind-body things, you can perform at the World Class
18 level. I did in sprints and in all different events. It
19 is not widely known. It is not widely applied. It is
20 just would be a wonderful thing for our society.

21 DR. GORDON: I will follow up. We will follow
22 up with each other because I think it is very important

1 both for us to get the input and also because athletes
2 are or can be such wonderful examples for other people to
3 have them talk about their experiences. So we will
4 follow up with that.

5 MR. SHINNICK: Right. I did talk to the people
6 at the New York City Ballet, sir. They would be willing
7 to come and talk about how they are treated, you know, in
8 a non-drug approach. A lot of these people need to be
9 treated for performances. So it is not a thing where you
10 treat and then it is just over. These are lifestyle
11 things. These are things that are ongoing to bring
12 homeostasis in crisis.

13 Also, you can't compete if you are sick. So
14 athletes have to learn how to be healthy, how to overcome
15 flu and colds and I certainly do this, you know.

16 DR. GORDON: Any other questions from anyone?

17 Yes. Go ahead.

18 DR. JONAS: I think, again, since the theme of
19 this particular two days is research, it would be helpful
20 to think about how to facilitate the discussion of how to
21 investigate many of these things because some of the
22 learning techniques that you are talking about in terms

1 of visualization in which you enhance your skills the
2 more you practice are not subject to blinding and this
3 type of thing.

4 So, again, a methodology issue, I think, comes
5 up. The same thing in terms of some of the complex
6 interventions, like what Upledger is doing with the
7 military; you know, very complex interventions, and how
8 to look at those separate from outcomes or just
9 observational research is important.

10 So, some suggestions in terms of that. I
11 wonder have either of you had dialogue with the military.
12 Both of you have military relevant themes, one directly
13 with veterans; the other has to do with sports.

14 MR. SHINNICK: I was in the military for eight
15 years.

16 DR. JONAS: I am wondering if you have any
17 discussion about whether the military is interested in
18 looking at these areas for enhancement, performance
19 enhancement or treatment of things like post traumatic
20 stress and that kind of thing.

21 MR. SHINNICK: This is a big issue, you know.
22 The research methodology, and I purposely didn't bring it

1 up because we could spend an hour on that, but I do
2 believe that if we wanted to address this issue in a
3 future meeting, I can enlist people who could actually
4 address the methodological problems with some of these
5 research designs and so forth. I think we know what a
6 lot of those are because we have sat through many of
7 these meetings.

8 I have seen at the NIH Consensus. I have been
9 involved for many years. But I certainly would privately
10 talk to you about that and I will submit something to the
11 Commission as a follow-up to that.

12 DR. GORDON: Great. Wonderful. Thank you.

13 MS. SCURLOCK-DURANA: I would also like to say
14 it took the Upledger Institute, the intensive program
15 took about a year to put together the protocol carefully
16 so that it could be in some way reliable, I mean, given
17 the complexity of what they were doing with the Vietnam
18 vets.

19 But they do have a protocol and all the
20 research data is readily available and could easily be
21 reproduced. They have contacted the VA and I don't know
22 at this point what the response has been, except that,

1 obviously, financially it is much more efficient to get
2 these guys back on their feet than it is to have be
3 maintained for the rest of their lives.

4 DR. GORDON: Thank you both very much.

5 Our third speaker is Richard Pavek.

6 MR. PAVEK: Thank you.

7 It is a good thing you welcomed me to come back
8 because I have got an awful lot to say and I figured I
9 could only get one thing done today, but I will be here
10 tomorrow for the next.

11 I am the director of the Chen Therapy
12 Institute, which works with emotional growth and in
13 development of treatments for emotionally caused physical
14 dysfunction. I am also director of the Biofield Research
15 Institute, which is involved in validating and
16 characterizing the human biofield, formerly called the
17 Subtle Energy Field Aura and Wei Chi and Biodomains.
18 Both are private, desperately underfunded organizations.

19 I am not trained in medical science, but for
20 over 23 years, I have been doing research on healing well
21 outside the pale of biomedical science and it is a good
22 thing because if I had been trained in medical science, I

1 never would have been able to develop the unorthodox
2 treatment methods and approaches that I have.

3 I would have been taught that everything I do
4 or teach to others to do is really placebo or works only
5 because I believe in it or is all just relaxation
6 response anyway or that it can't possibly work because
7 there are no published studies to show that it can.

8 Notwithstanding that, I have developed non-
9 drug, hands-on treatments that halt migraines, end panic
10 disorder, post traumatic stress disorders and empower the
11 disempowered. There is no way that my work can be
12 explained under the current biological model under which
13 biomedicine operates. This is because the current
14 ontological model of biological medicine is not large
15 enough to explain the living human being.

16 Everyone in this room knows that our emotions
17 are involved with every aspect of our lives, our mental
18 functions and our organic functions but biomedicine does
19 not have a concept of emotions being causative factors in
20 their own right. Emotions are only derivative factors.
21 As an example, just four days ago, I looked in the index
22 of Cecil's textbook of medicine at the medical bookstore

1 at UC-SF. The word "emotions" is not in the index.

2 Not since the Greeks adhered to the concept
3 that humans consisted of a physical body conjoined with a
4 soul body that infused the physical body with the
5 emotions have we had a way to understand how emotions
6 could directly effect and disrupt the physical body.

7 Current biomedicine does not accept the concept
8 of a biofield. It does not use the concept of a soul.
9 Personally, I happen to believe that what the Greeks
10 called the soul is what we now call the biofield. Proper
11 research into these methods and other CAM methods simply
12 cannot happen from the narrow perspective of
13 biomedicine.

14 Look at acupuncture --

15 DR. GORDON: You will have an opportunity.

16 Are there questions for Richard Pavek? Any
17 questions at all?

18 MS. KERR: I just think that is pretty
19 startling, to say the soul is the biofield. I would be
20 very interested in that.

21 MR. PAVEK: It is. It has taken 23 years for
22 me to get there.

1 MS. KERR: Congratulations.

2 DR. GORDON: Richard, are there any specific
3 research suggestions that you have for us?

4 MR. PAVEK: Well, basically, one example that I
5 wanted to give is what happens when you try to examine
6 some of these what we often call mind-body disciplines
7 from a strict biological or biomedical position. I have
8 seen this happen in many ways, but look at acupuncture.

9 Acupuncture comes to us saying, gee, there are
10 these meridians in the body and if you do these certain
11 things, you can treat certain disorders. Biomedicine
12 over here started out by saying this is ridiculous. We
13 know there are no meridians in the body. We would have
14 found them by this time if they had really been there.

15 Then one day, they discovered that if you
16 needle people, needle the meridians, endorphins were
17 produced. So now what you hear out on the street is, oh,
18 now we know why acupuncture works. It stimulates
19 endorphins. Therefore, it may be useful for some pain
20 conditions, but that is all. It couldn't possibly work
21 for these other things that it works for.

22 Well, the production of endorphins is just a

1 very minor factor of what takes place. My point is that
2 unless you have some kind of a view of the human body or
3 the human being that encompasses something beyond just
4 the strict brain directed, physical body, you cannot
5 understand how some of these things work and you cannot
6 apply proper research methods to be able to research them
7 more fully.

8 DR. GORDON: Thank you very much.

9 We are going to have the next panel come up
10 now. If Thomas Glonek is here, he should come. Crystal
11 Concoidal [ph], Linda Lazarus and Sandra McLanahan. I
12 think it is the two of you.

13 So let's begin with Linda Lazarus first and
14 then Sandra McLanahan.

15 MS. LAZARUS: Please let me know if I start
16 speaking quickly. Particularly, I am going to be reading
17 some things.

18 I am, I guess, a different kind of speaker. I
19 am a lawyer, and I am also a mediator, and I am really,
20 really speaking as a mediator because I am about to speak
21 about conflict. There is a lot of conflict surrounding
22 the extremely important work of the White House

1 Commission.

2 Speaking as a mediator, there are some ways
3 that are better than others to resolve conflict. I think
4 that this meeting is an excellent beginning in terms of
5 beginning to air issues and beginning to listen to
6 things. Maybe I have a few other suggestions that might
7 be useful to some people.

8 I think that there is a consensus about a few
9 issues involving alternative complementary modalities. I
10 think that everybody in this room agrees that these
11 issues are very important, whether and how we can
12 integrate Western and non-Western methods of healing.

13 I think everybody in this room also agrees that
14 the issues are very difficult and very, very complex and
15 that people have very, very strong feelings about it. I
16 think people also agree that there is an enormous amount
17 of scientific information that people are relying upon to
18 support their different positions and that at some point
19 people are going to have to make some sort of sense about
20 the scientific information, which will be an extremely
21 difficult job because there is just so much of it.

22 I think maybe that is where the agreement sort

1 of ends, but maybe I am wrong about that. It would be
2 nice if I was wrong about that. So the question is, when
3 you have a conflict that is complex, that has strong
4 feelings, that is important, that is based on scientific
5 information, how do you go about making decisions,
6 hopefully, making decisions in a positive way that makes
7 the conflict itself constructive rather than destructive?
8 How do you find a way of resolving the conflict without
9 causing more harm?

10 I think that the techniques, the tools of
11 alternative dispute resolution, particularly those that
12 have been used for environmental disputes, of which I
13 have no particular expertise myself, but I have an
14 excellent working paper that I can suggest and share with
15 all of you by some of my colleagues that is fabulous,
16 about how to deal with complex scientific and technical
17 issues that involve these sorts of emotional intensities
18 and that deal with very important issues.

19 That is basically what I have.

20 DR. GORDON: Are there any questions or
21 comments? Yes, Joe.

22 DR. FINS: I think it is an extremely important

1 question, and I was wondering, in science, in clinical
2 medicine at least, we rely upon peer review. I think you
3 are suggesting, maybe you could expand upon this, that
4 there are different groups of peers. Could you perhaps
5 expand on whether or not peer review is a mechanism of
6 ADR that might be helpful or inadequate, whatever?

7 MS. LAZARUS: Peer review itself is not exactly
8 a mechanism but some aspects of peer review partake of
9 the mechanism. Simply, when you have a group of people
10 all concerned with an issue, exchanging ideas, if you
11 have a facilitator that helps you really get to the nub
12 of what the conflict is, to sort of keep reducing down
13 and reducing down and reducing down, until people see
14 that, let's say, in the area of medical research and why
15 medical research isn't verifying or confirming some
16 things that people involved in alternative modalities
17 think are the case.

18 Perhaps if a physicist and a medical researcher
19 sat down together and the physicist said something like
20 all matter is energetic and the medical researcher said I
21 am not too sure. I am not starting with the energetic
22 nature of the human body and there was a facilitator

1 there, I mean, there might be some growth if you have the
2 conversation to start with.

3 If you never have any conversations, there
4 won't be any growth. Or maybe the medical researcher can
5 convince the physicist that they are looking at the
6 nature of reality erroneously, but I don't know. So
7 talking is always the first step. If you don't talk,
8 nothing happens. So this meeting is wonderful.

9 But there has to be more than just getting an
10 enormous amount of information. There has to be some
11 focus. There has to be some intentionality of getting
12 meaningful information and of healing the risks between
13 the traditional and medical community and the non-
14 traditional community because if the non-traditional guys
15 just come in and take over, they will be no better than
16 the people before them.

17 So that, to me, what is most important about
18 this process is openness, letting everyone participate,
19 really asking the hard questions and really having
20 someone, not me, because I don't know enough to do this,
21 but someone probably with environmental dispute
22 resolution experience. I can think of some people who

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1 would be really wonderful. Start having these
2 conversations because these are important conversations.

3 DR. GORDON: Any other questions here?

4 Tieraona.

5 DR. LOW DOG: I just want to thank you for
6 raising that whole point of conflict resolution. I think
7 you are right. I think that in my own experience there
8 is nothing harder to come to grips with with your own
9 beliefs or somebody else's and that in some ways a
10 physician or a Western-trained practitioner may have it a
11 little easier because if they have a hypothesis that is
12 rejected, they don't have to quit medicine. We haven't
13 said all medicine is bad. But in some ways when we say
14 naturopathy or chiropractic or biofields or other types
15 of medicines, when we challenge that whole paradigm or
16 perspective, what we are really saying is your whole
17 belief system doesn't work or doesn't exist. I think
18 that is a very emotionally charged area to get into.

19 I, for one, would appreciate any of the working
20 papers or anything that you have on this because I think
21 it is something to address.

22 DR. GORDON: Thank you.

1 Wayne.

2 DR. JONAS: Yes, I think conflict resolution
3 and the building of trust between different
4 constituencies is extremely important and I would
5 appreciate also some specific suggestions as to how this
6 commission could, in fact, encourage that in some way and
7 especially focusing on an issue of when there are major
8 power differentials between the constituencies, how you
9 go about that because even at a round table, there is a
10 head or tends to be. So, again, how is that managed in
11 some way is a big question.

12 MS. LAZARUS: That is an excellent question.

13 Lenny Marcus at the Harvard School of Public
14 Health was at a Society of Professionals in Dispute
15 Resolution Conference a few weeks ago and I was chatting
16 with him. I asked him what he thought about, you know,
17 how do you solve a conflict between traditional and non-
18 traditional medicine. It is not the same as solving a
19 conflict between a patient and a doctor, but it seems to
20 me on many levels, I mean, it is talking about
21 integrating two paradigms.

22 He thought it was an interesting thought and he

1 thought that maybe it would be a good question for a
2 conversation that they are planning. They are planning
3 on having a series of conversations. I am sure, you
4 know, he probably would be a good person to start with.

5 DR. GORDON: Please feel free to send us that
6 material. It would be helpful to us.

7 Thank you.

8 Sandra McLanahan.

9 DR. McLANAHAN: I am just so encouraged. I am
10 speaking as a physician and researcher and mainly as a
11 public comment to say a few suggestions in terms of
12 research. Having watched this transition that took place
13 in the beginning of my medical practice from natural
14 childbirth being something so separate in separate
15 birthing centers and then gradually a little bit of it
16 available in the hospital and now you can go into any
17 hospital and ask for natural childbirth and it is an
18 option.

19 So I see the hope of, within another 10 to 15
20 years, walking into any hospital in this country and
21 having those options available, homeopathy, and
22 acupuncture, and yoga, and mind-body medicine right there

1 in the hospital. It is so important.

2 Dr. Michael Lerner and I got a grant from a
3 private foundation to go around the world and look at all
4 the alternative complementary cancer centers. We went
5 around North America, Mexico, Canada, Bahamas. We
6 visited all the European spas. It was a tough job, but
7 somebody had to do it. We went to the Orient.

8 Mr. John Fink, who had lost a child to cancer,
9 wrote a book called "Third Opinion." From that
10 investigation, I guess I just want to say that in terms
11 of research, there are two basic questions: how to expand
12 the research that really makes an impact on medical
13 schools. That is my point today, that if we don't get
14 this to the medical students, it has less of an
15 opportunity to really change the practice of medicine.

16 I think, first of all, I want to suggest
17 redoing the Chantilly Report. It had an enormous effect
18 on practitioners of alternative medicine, to make them
19 aware of the possibility of doing research and of looking
20 at using the Western paradigm, but particularly within
21 that research, choices, help make better choices at the
22 NIH. Emphasis on child rearing practices, starting with