I forget the word you used, and I should know it -- of how you have your little check consciousness to see where the new paradigm is going through all the services and departments.

But for me, and I just wanted to say this, and then give me some input, is I often see the implications at the architectural level, you know, the environment. Do we have trees, things that even I see, used and identified a while ago, with light and clocks, the crazy TV that is on in all the OPDs, which is the most mental-level garbage at such a critical time.

I guess because I have a unique expectation of qi, because I know they are doing it and it is consistent with the mission, can you fill me a little more on that aspect of how the environment of the hospital is consistent with the ecological paradigm. Even the disposable and recycling, the challenge is incredible for a health care system.

DR. HAMMERLY: Thank you. There is an awareness of that as we are trying to integrate this philosophy at multiple levels, financially, with healthy communities, with educational strategies and so on. The

environmental facility definitely needs to be addressed as well. The fluorescent lights and the food, and all those other issues definitely need to be addressed. Plant therapy, having plants in the rooms, I think, would be another useful thing.

There is no organized initiative around this, but several of the hospitals have this Healing Environment Committees and are looking at models that are changing the environment to more holistic, and not as sterile a setting.

DR. GORDON: Dr. Hammerly, it is wonderful to see what is happening in your hospital system. I am wondering what you see, first of all, the deepest lessons you would like to teach us, the obstacles you have to moving in a more comprehensive and integrative direction, and what your hopes would be, in two minutes.

DR. HAMMERLY: In two minutes. The primary obstacle has been philosophy. Everyone has talked about physicians wanting data on safety and efficacy. Some physicians, you can stack the studies up and they won't listen. They won't be bothered with the facts.

So we need to address philosophy, and that is

why we spent so much effort on that, defining why on earth you would want to do it, creating a rational strategy of how you would do it, and then making sure that it is consistent with the organizational mission and values. If it is not coherent, and you have organizational dissonance, it is going nowhere.

The other, is that it needs to be very much tailored to the specific location and environment. It can't be a one-size-fits-all approach. So you need to be sensitive to, again, consumer interests and readiness, availability of services, physician readiness, politics. There are a lot of factors that come into play that need to individualize that model.

But if the overarching philosophy is solid, then that organization will find ways of providing that more comprehensive, collaborative, individualized care. I did include one quote that I think is very illustrative of the collaborative philosophy that was attributed to Mother Theresa, and it says, "You can do what I can't; I can do what you can't; Together we can do great things."

DR. GORDON: I just wanted to come back, for a moment, to where you would like things to go. Here you

are speaking to 70 different hospitals, approximately.

Where do you see things going, and how can we help move the process ahead for these 70 hospitals and for others?

DR. HAMMERLY: I didn't spend a lot verbally talking about the financial issues, but it is really a concern. As much as we have a mission to provide this type of care, there reaches a point where you can only subsidize it so long, where it needs to be able to support itself.

So I think being creative and coming up with new models to fund research, new models, reimbursement models that aren't trapped in the old assumptions, I think, would be very important. Right now, it is subsisting on subsidies, for the most part. It is not self-sustaining. I think creating the mechanisms to make it self-sustaining is very important.

DR. GORDON: Do you and those you work with have some ideas you could share with us as we move ahead toward thinking about reimbursement?

DR. HAMMERLY: Yes, absolutely.

DR. GORDON: That would be very helpful.

One final question, and then we need to go into our own discussion.

DR. FINS: It follows Jim's last set of questions. I was wondering if you have the sense of the economic implications in real dollars, sort of following Tom's question of Dr. Dillard from Oxford.

I mean, what percentage of your cost structure, or your fed tax, or your per diem, or whatever your denominator is, would be ascribed to CAM as it is currently practiced, as it might be practiced in five years, and what your long-term goals would be, because I think that if we are talking about funding strategies and reimbursement strategies, we need to know what the number is.

So you would have an experiment in progress with 70 hospitals, and it would be really helpful for you to give us some spreadsheets and economic projections, because I think we can multiply that and use it as a proxy for data that would be very hard to obtain in other settings.

So if you could provide that to us, it would be immensely helpful.

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

How many people here on the Commission have to leave at 4:45?

[A show of hands.]

DR. GORDON: Okay. What I would suggest is we literally take three minutes, and then we come and focus. We will go beyond 4:45, but we would like to hear from those who have to leave first, your thoughts, your considerations, so you have an opportunity to get your voice heard before you leave.

So let's take a three-minute break, literally.

[Recess.]

DR. GORDON: Some of you have to leave at 4:45. The bus is coming to take people back to the prison at -- oh, to the hotel at 5:00.

[Laughter.]

Session VII: Commission's Discussion

DR. GORDON: This is going to be very much an open discussion. We would like everyone to have a chance to share your thoughts, share your observations, share the concepts that are coming up as a result of this

discussion, thoughts about the future and future directions, whatever has come up for you in these last couple of days. So, please, just go for it, each person.

Oh, Michele has an announcement first.

MS. CHANG: If the Commissioners will go to Roman numeral VII in their tomes, you will notice there is a Top of Mind, these sheets here that you can write down your thought that you want us to capture. This is what you suggested last time. Hand them in to me before you leave today, or just fax them to us when you get home, but this is a way just to capture them. Then we will put them in all one document for the next meeting.

DR. GORDON: Okay. So let's just go for it.

Tom?

MR. CHAPPELL: I have a couple of thoughts. One, I am thinking about the overall goal and vision of where we want to be pointing ourselves, and I think we do need to affirm the equal importance of promoting wellness as over and against healing, if you will. Once we create that equal value, then I think we need to see CAM as having two charges. One is equal rights, and the other is equal accountabilities.

DR. GORDON: Okay, great. Thank you.

MR. CHAPPELL: I would like to comment. The reason I am talking about equal rights, equal accountabilities is that it is not clear to me that all aspects of CAM want to be integrated or can be integrated, but if we create equality, then the marketplace can integrate if it wants to, integration can occur wherever it is natural.

But I am not sure integration is what we should force. We can create the possibility of that in the marketplace by simply striving in our goal to create equality for CAM practitioners.

DR. GORDON: David?

DR. BRESLER: Well, another thing that seems to come up a lot is about early education, letting people know two things: No. 1, what they are doing that is deleterious to their health, whether it is chemical sensitivities or lifestyle kinds of behaviors; and No. 2, letting people early what they can do in order to enhance and improve their health.

I think it is probably elementary school, junior high school level, if not earlier, that we

probably need to start. This is an area that I would like to see addressed at some of our future meetings.

DR. GORDON: Great. Thank you. Other thoughts?

Veronica. Please turn on the mike.

DR. GUTIERREZ: What I think would be very helpful, for me, as I tried to understand more about the different CAM services is to have from each group a statement of intent and purpose.

For example, I heard Chinese acupuncture is different than the licensed medical physician who practices acupuncture. If I knew what the intent and purpose of each provider group, that would certainly help me understand when something might be appropriate.

As far as chiropractic goes, there are a lot of professions that do manipulation, and I have no problem with that. I wouldn't interfere with anybody's attempt to secure it, but for me it is important that people understand that adjustment is different than a manipulation. It is a different intent and purpose.

So it would help me, as well, to educate my commission members and the public.

DR. GORDON: Thank you. Yes, please.

MR. ROLIN: I know we talked about access at this meeting, and we are going to be talking about reimbursements and all these other legal issues, all that in the future before we complete a report, but I just want to emphasize again, and we have heard it brought out so many times here, is we want to remember the underserved, those that aren't being served. We want to continue to remember that and make sure that we address those issues.

This is wonderful to be able to have this new issue of CAM. I hope it gets, certainly, and I know it will be, introduced on our reservations for our Indian tribes because I can see a vast improvement there happening within those communities if we utilize that.

So I would hope that we would continue to address those issues and remember in that perspective the people we are here to serve, and I know we will. I just wanted to reiterate that.

DR. GORDON: I have a question back for you. Are there groups, especially among the tribal groups, that you would like to have come talk with us?

MR. ROLIN: Well, I am working on that right now. Mr. Leo Nolan was here from the IHS this morning. I spoke to him and I spoke to other folks, and we are working with that. Hopefully, I am going to have a group at the Town Meeting in New York.

DR. GORDON: Terrific. That's great. Charlotte. I am just reading your mind.

SISTER KERR: You did a good job, only I am not very clear here. I want to share some thinking, and I want to affirm what has gone before.

One of the outcomes, for me, today has to do with what I think I want to hear in the future. I will give you an idea so that you can help me with it. For example, when we talk about nutrition, I want to know why the Department of Agriculture is not here on the same panel, or why the environmentalists are not here on the same panel.

Let's assume we want to have this panel on rethinking economics. I want some Fortune 500, some multinationals here, and the pharmaceutical companies. I believe most people are good, along with Anne Frank. I still believe that. It is like the docs and the nurses,

they were called to healing, and they are frustrated because they are not getting to do their vocation. Most of the time, I think that is what a lot of the frustration is about.

I think these companies want to be called to service. The research in fibromyalgia, in the toxic chemical crowds, they said the company that did the one that found out they were psychogenic was done by the chemical companies. I think that part of our job is seeing that this is cutting through all the disciplines. How do we do that? We can't talk about health care. It is like talking about sick buildings. This is one of the ones that was labeled a couple years ago, wasn't it? They had to redo a whole lot of stuff.

But I think it is really asking us to stretch on, how will we recreate some new panels across these disciplines. I mean, Monsanto, maybe, needs to be here. Or else, you all don't think that makes much sense.

DR. GORDON: Would you like some feedback?

SISTER KERR: Yes.

DR. GORDON: I think it is an important enlarging of our mandate, and I think we should have some

discussion. It would be good to hear from people.

Do you want to address that, Effie? Joe?

DR. CHOW: Actually --

DR. GORDON: Please put on your mike.

DR. CHOW: I'm sorry.

[Laughter.]

DR. CHOW: Project, project.

Really, it was sort of what I thinking about, because we are not talking about just health care. We are talking about life. So therefore, all that you mentioned, like the big business and economists and environmentalists, and all of that, including the schools, the school representation and children, because that is where we are going to be starting, the education, if not in utero.

I think what was impressive about some of the things that were brought up is that it was going beyond the methodologies and the techniques. Quite a number were talking about before that really lifestyles, not just techniques including CAM into the system. I think what Tom was mentioning was, maybe they are not all to be integrated because what we are talking here, I am

concerned, is integrating into the medical system as it is, and being judged by FDA as it is. There were a few that mentioned, maybe we need to look at other paradigms. I think we need to really, really keep that in the forefront.

The other too, that spirituality is really important. It is sort of links up somewhere, but I think it pervades throughout. And then, subtle energy. The subtle energy is what makes CAM different, if we are going to call it CAM. And I really don't even know whether CAM is a good term or not. We should look at that and see what it is.

So I agree, expanding that area and invite others. I would like to see a panel of the skeptic, too, as well.

DR. GORDON: Okay.

SISTER KERR: I just have one response. A group I left out, because we may need names and I don't have them. The more I hear us speaking in the wellness model -- and my own bias is what is traditionally called the public health model -- I think we need to look for some public health people who are also CAM people because

I think we are heading that way. Thank you.

DR. GORDON: Great. Joe, you want to say something?

DR. FINS: First of all, I want to just thank everybody on behalf of everybody.

[Laughter.]

DR. FINS: Because I just think as the group gets bigger and bigger, it just gets better and better. I just think we are really coming from different places, and I think we are just getting along terrifically and it is just wonderful to be part of this group. I thank you all for your friendship and your collegiality.

COMMISSION MEMBER: Joe for president.

DR. FINS: No, no, no.

[Laughter.]

DR. FINS: Thank you. Thank you. Well, if I am nominated by my party.

Let me just endorse what Charlotte said, and I think maybe we can take advantage of that in New York with some of the corporate leaders, and maybe Tom can help build bridges there, we can get some people to testify.

I had a few points, just off the top of my mind in response to Buford about the access issue. I think that one important issue is that we were talking about access, for the most part, in the last couple of days, in the context of people who had insurance. I find it ethically troubling to talk about access to CAM therapy when we don't have access to therapy, whatever it is.

I think the universal health care should be something that is a basic right of an American citizen. I think it is going to be ethically difficult to argue for therapy of one sort when people don't have a basic health care package.

This is sort of stream of consciousness here, but when we talk about our report, I think there really are two stages. There are broad articulation of principles that I think we need to make, which will set the agenda for 5, 10, 15, 20 years, and then there are concrete recommendations. I think sometimes we get into disagreements because we are confusing a principle with a concrete recommendation. I think we have to have clarity about that.

Fourthly, I think that we have to have a better

sense of the sociology of CAM. I think it is going to be important to make the case to those who are somewhat more skeptical than the people we have had visiting with us over the last several months. I think we have to understand the fonts of this enthusiasm and interest.

Finally, I was very impressed by, again, Dr. Quevedo's work at his hospital. I think that this Commission is going to start a process of dialogue, and we have to think about mechanisms that sort of institutionalize conversation and dialogue, neutral mechanisms that everybody finds trustworthy, even those who are skeptics of regulation, because what Dr. Quevedo did in his hospital, bringing everybody together onto the same page, we need to do nationally, appreciating a variety of constituencies, people who will live for this and die for this, and people who will die trying to have this never happen.

So I think we have to think about mechanisms and agencies and collaborations that allow dialogue to follow us when we are no longer here.

DR. GORDON: Terrific. Thank you. Conchita and George.

DR. PAZ: Well, in looking over the last couple of days, one of the things I had thought about also was, since this was our topic, access, I think access definitely for the diverse cultures that we have, not just Hispanic, not just Indian, not just black, but also all the different Asians.

I mean, our culture here in the United States has become incredibly diverse. So as you start looking at the different alternative therapies, actually the list can go on, and what we are just doing is just talking about some of the more common known ones that as time goes on and this gets to be developed, it will grow from there.

What I do want to see is that they do become available and if someone feels like they need to access that, it is available to not just you and I but also the impoverished. I think that is incredibly important.

But not just that. We know that our patients that access alternative therapy, and so we want to also know what they are doing to their bodies as part of the health care that we provide for them.

So they talked about, in some cases, where it

was separate from their regular health care, and I am looking at it to see, is it something that would be more integrative like what some of the other clinics have mentioned. So I thought that that was very important to see that, to see how successful some of the integrative medicine was going. I would like to promote that as well.

DR. GORDON: Great. Thank you. George.

DR. BERNIER: It has really been a fantastic couple of days, and I want very much to complement the staff that put together the program and all the participants.

DR. GORDON: Yes.

[Applause.]

DR. BERNIER: In many ways, I thought it was in a class by itself compared to the prior two, but maybe it is just that we are all much more comfortable with each other and we talk about our dirty linen, et cetera.

But one of the thought I am taking away from it is that the time is so ripe now for a major step. I see this as my own institution where nobody knew how to spell CAM, and how everybody is one.

[Laughter.]

DR. BERNIER: But there remains, clearly, some issues. One of them is that it is only going to be, to my mind, by guaranteeing the safety and efficacy of treatments of all types that we are going to be able to get buy-in by the medical community. I personally really hoped that the medical community is going to be able to buy in, but to have the guidance that was laid out for us with the President's charge.

One of the problems is that the name "CAM" means so many different things, and I am not so sure that a whole lot of individuals who are in CAM disciplines are eager to see an integration with traditional medicine. We certainly heard that today many times over.

So I think we have come a really long way. I feel I have come a long way, for one, and I do think that the time is ripe for making a major step.

DR. GORDON: George, a couple things come to me. One is, I wonder if you can work with us -- we have been talking about this some -- in bringing in even more of the traditional medical community, particularly the AMA, AAMC, and working to involve them in our

deliberations.

DR. BERNIER: Yes. I would be very happy to do that, and I have begun to do that on a different canvas.

DR. GORDON: Great. The other thought that is still hanging in the air that I wanted to ask about is the issue of universal health care.

I just want to check in with everybody and see if the feeling is as strong as I think it is about addressing this issue and not just addressing CAM in that context, the issue of making some kind of statement as a commission or taking some kind of testimony about the need for universal health care and different ways of providing that.

SISTER KERR: [Off mike.]

DR. GORDON: I am asking, are you as commissioners interested in that issue, interested in exploring it with the possibility of an imprimatur.

SISTER KERR: [Off mike.]

DR. GORDON: No. I understand. I am not asking for a decision. I am asking for an intent to explore the issue, which Joe raised.

DR. BERNIER: Jim, I would be very much in

favor of that. I think it is going to be so hard, it would be almost impossible to get the one without the other.

MS. SCOTT: [Off mike.] Is it on? But to me, universal health care means making a very firm statement about our belief that health care is a right, wellness is a right. I think CAM fits in very well with that.

I am not as comfortable with the marriage of conventional medicine and CAM yet, although I understand politically we may have to make a statement toward that. But I think just having a statement that says that we believe that this is a right, and as a right, it is a right for all citizens, and to really look at the issues of access, and especially the affected populations.

So personally as a commissioner, I would like to see many more African-Americans, both as panelists and speaking at the open debate, because I see that as a real gap. I think the job we have been given is enormous, and I think it is really going to be hard, over the next several months, to really figure out what, of all of this, we might be able to speak in any substantive way.

So as we do that, for me, the concern about

access and making sure all citizens are going to have access to this is paramount for me.

I do get concerned about some of what I have been hearing. In some ways, I think people see CAM as sort of a second class, and see it as something that might be okay for conditions that are mainly seen as affecting those people who are not as valued in our community, such as for addiction. We are willing to experiment and maybe put a few dollars in that whole area, mental health.

So making sure we deal with it from a wellness perspective in terms of being well physically, mentally, spiritually, and economically, I think we have to keep broader umbrella out there.

DR. GORDON: Tom. George has been waiting patiently. George, do you want to say something, and then give it to Tom?

MR. DeVRIES: Oh, go ahead, George.

MR. CHAPPELL: Tom, go ahead. Then I will go next.

MR. DeVRIES: Oh, thanks. I wanted to affirm what Julia was just saying about the broader scope of

wellness than the term "universal health care." I want to be careful that we don't buy into political language that take us off the mark. That's all. I am for getting to where you want to get, but I want to get there in a more circumscribed manner of wellness.

Now, what we need right now for CAM is liberation theology, which is what women have done on the globe. It is what minorities on the globe, and it is a process of affirming the essential inherent worth of the entity involved.

By affirming the essential inherent worth, there is nothing more ultimate. It is raising it to that ultimate level and saying to the men, women are equal, and saying to the Western medical community, this paradigm is equal. That is the first thing we need to do in terms of our strategy, is raise it up, affirm it, because it needs to be affirmed and it needs to be raised up by some group, and we are the group.

So that, for me, is, again, the starting place, the equality, the raising up, the affirmation. Then a lot falls into place after that. I think we have to get there first, and then work backwards.

MR. DeVRIES: I would agree, Tom, with your comment in the sense that we have to raise, shall we say, the perception of CAM to one, certainly, of equality.

I think, one, I would also caution the Commission that whatever recommendation we go forward with can be applied on multiple tracks, that with universal health care, the current private sector system, there are influences beyond this commission that ultimately will make those determinations as we go forward.

Yet, the work that is happening here is so important for the future of CAM that we don't want it tied to one political solution that may or may not happen. Yet, I believe the recommendations we can make can be applied to multiple tracks, regardless of where our nation decides to go in terms of a policy of health care coverage.

I mean, we have heard testimony here in the last couple of days that have talked about chiropractic, in particular, even though it is not mandated as a benefit, is perceived to be more mainstream because they are covered so routinely. I personally have seen studies

that just recently have come out that said the majority of employers anticipate, over the next five years, adding broad-range CAM benefits -- not chiropractic; beyond chiropractic -- for all their employees.

So I guess my encouragement is that as we go forward and we create our recommendations, that they can be applied to multiple tracks, regardless of which way our country moves forward with its health care policy, and that they can be applied in either or both scenarios because we really don't know the outcome of our country's future.

Ultimately, those issues are really based on what we are talking today. It is the issues of research, it is the issues of education and licensure, it is the issue of, really, how to lift up these provider groups that we are talking about into one viewed on a level of equality based on the safety and efficacy.

DR. GORDON: Tieraona, Bill, Joe.

DR. LOW DOG: I am trying to collect my thoughts. For myself, I don't want to get, just, hung up in modalities about all the different practices out there, that there seems something far more fundamental

than that, even more fundamental than universal health care.

We get glimpses of it. You get glimpses of it every day when you are sitting in your office with your patients, that it is kind of foolish to think that you are going to have a health individual if they are not living in a healthy family, and that healthy families can't survive if they are not in healthy communities, and that there have to be social policies in place that allow for healthy communities and healthy families and healthy children.

We talk about diet and we talk about nutrition, something so fundamental, yet it seems so difficult for so many of my patients, and it really does because they are so stressed.

Single parents with three kids. Getting them up in the morning and trying to get them all out to school. Getting to work late, and you are in trouble with your boss, and then running out for the Big Mac at lunch time, and having a quick Snickers in the afternoon because you are so tired. Then you go run and pick them up, and you have got to get him to Boy Scouts, her over

to soccer. You come home and whip up the macaroni and cheese, and you help them out with their homework. Then you throw them in bed, and you do the laundry, and you go to bed, and you are exhausted.

I mean, it is so big. You see what I am saying. It is so big trying to make changes. Well, it was exhausting just listening to it.

COMMISSION MEMBER: We are all exhausted.

DR. LOW DOG: It is people's realities, though. That is the reality of their life, and that is the reality of the patients I interact with. Even as a physician, I am told by my office manager, Tieraona, you either have to cut back on Medicare patients or you have to see them in a shorter time because we can't sustain a practice of 65 percent Medicare and Medicaid when you take 30 minutes with a patient.

So I have to change the way I practice or we can't survive. So I am questioning the whole reimbursement issue a little bit, because under the system it is right now, it is very hard to survive. I think that I am in favor of trying to come up with the very essence of what all medicine is about, which is

really public health, to me. I mean, much of this comes back to public health, education, education on health and wellness, nutrition, diet, exercise, movement, music, healthy work policies, all of those types of things, and then health care for everybody.

You know, it is nice to talk about nutrition, but when you go out on some of the reservations, you go out to some of the rural areas where kids tell you that the only way that for sure they are going to get lunch is if they go to school. Before I get to wanting to reimburse for everything, I want to make sure there are some real fundamental aspects of health that we take care of.

So I hope that when we are talking about all of these things that we don't lose track, that that is part of the voice that I hope that we can have. Then all of these other things begin to fall into place, but we still have a long way to go just to get the basics down.

DR. GORDON: Great. Thank you.

DR. FAIR: Well, I would just like to perhaps add a mild dissenting vote against the universal health care thing because I am afraid that would be a balloon

that people would shoot at and miss our main message.

We have heard two days of talking about what CAM can do in both treating chronic disease and preventing chronic disease, and you all got tired of hearing me ask the same question, what is the solution to use this, whether it is to prevent heart attacks or cancer or whatever, and it was education. Yet, we heard nothing concrete about how we increase education. Private groups have been trying to educate people about various diseases for decades, and it hasn't made much of an impact.

I guess my comment would be, I think we ought to come down. We ought to really stress developing a plan for universal health education, not necessarily universal health care, because I think if we educate people universally, the family improvements will follow, the community improvements will follow, when people are aware of how much this means to them as individuals. By extension, it will go to their community.

I think, Jim, I would like to see in the future. Maybe this is really walking on thin ice, but I would like to get some input from someone like Senator

Harkin. I mean, is it absolutely impossible to even consider making recommendations that there should be legislation for health education every --

DR. GORDON: Let me answer that right now. I have spoken with Senator Harkin. He and I have spoken precisely about this. I said to him that this is one of the areas that I was particularly interested in, and as I was talking with other commissioners, I had the feeling there were a lot of other people who were interested as well. He is definitely interested.

DR. FAIR: Good.

DR. GORDON: I think that is within our purview. The other thing I want to address is that we had some on health education here. For example, ARRIVE is basically a health education program. We are going to be focusing in the next two meetings on professional education and on public information, which includes -- I see it very strongly -- education in the schools and in other places as well.

So again, I hear the strong focus on education and on public health.

DR. FAIR: I mean, I think we have to have a

mandatory thing in schools.

DR. GORDON: We can talk about it. We can bring people in, and we can make up our minds. If that is where we come down, and it sounds like it may be, I think that will be a recommendation. We have to think about how to manifest that in legislation, but I think it is a basic principle of it. If it is one that we are accord with, we will put it forward.

DR. FAIR: I think innovative thinking also. I did it, say, tongue in cheek drawing the analogy between if you can get a preferential insurance rate for your automobile because you take a course in safe driving, why can't -- I mean, seriously, why can't you get preferential insurance rate on your personal insurance if you take a course in how to maintain your health. I mean, that doesn't seem too far fetched.

COMMISSION MEMBER: If you don't smoke, you get --

DR. FAIR: If you don't smoke, that's right, but you can eat 10 cheeseburgers a week. I mean, I don't know, it is just one of the things to think about.

The other thing is that I think that -- well,

we will talk about reimbursement another time. I also would like to hear, in the future, something about spirituality in CAM, how we incorporate it, because I am not clear how to do that, although I have heard a lot of speakers talk about it.

And the last thing. I heard here today something that -- I don't think I was paranoid about it -- but the comments about research within academic centers almost vis-a-vis non-academic centers. We heard Dr. Quevedo's excellent presentation. I think that research on CAM in an academic center is very difficult to do. I think that properly designed studies on people like he is talking about, I think you can do better research and non-life threatening CAM modalities outside of academic centers than you can do inside, perhaps.

So I would think whatever our recommendations would be with research, we ought to have it broad enough, and we ought to talk about it in the future so it could allow research in both areas, both venues.

DR. GORDON: Terrific. I think we can certainly shape the next research panel to reflect some of these concerns. I don't mean to be sort of answering

the questions as if to put them to bed, but we have been thinking about including spirituality very much as part of the wellness meeting as well.

Joe.

DR. FINS: You know, I think that CAM is not the diagnosis. It is a symptom of the problem. Why is there so much interest in CAM? It is because the health care system hasn't been as caring or accessible as it needed to be.

So I totally agree with health education. I don't want to get mired in the debate about what we are going to call the health care entitlement, but I do think that it becomes very difficult to articulate a benefit in one context when we don't have the benefit in the other context because it kind of gets to be like a Plessy v. Ferguson thing, you know, separate but equal.

We have to overturn that way of thinking. We have an opportunity here, as you said so eloquently, to have a new manifesto for medicine. We don't want to recapitulate the old problems by creating those who have and those who don't have. So I think the theme here should be to respond to the needs of the people who are

crying for help. It becomes, I think, philosophically impossible to grant access to some modalities while you are saying you are not enfranchised for other modalities when we are saying the whole goal here is to integrate modalities, not to give people entitlements but to promote human good.

So I think that I agree with Tom and others, I don't want to get mired in the political discussions of 1994. I don't think that is going to be productive, but I do think we have to talk about access to care. Care should be the goal here. There are educational components, there are environmental components, there are agricultural components to this, and there are health care benefits that are integral because what they do is they allow people to live more fully.

So I want to just be very clear that it is not to politicize the discussion, but just to make the argument ethically cogent because if we don't include both ends, we are going to have problems justifying one entitlement and not the other.

DR. GORDON: Wayne, Tieraona, Tom, and Don. Did you want to speak, Don? Ming definitely wants to

talk.

DR. JONAS: Actually, I would take one step further back and say probably the most effective use of resources would be health care advertising, maybe even more than education, and perhaps we should advocate that.

I mean, part of the lifestyles dilemmas that we are in have to do with the very effective marketing strategy for things that aren't very helpful for you. That is the way that values are currently communicated in our culture, or the majority of them.

I want to get to a word that hasn't been used, that actually was the word that I suggested originally for this part of our discussion, but before I get to that, I want to say that I think that our discussion is and needs to be grounded in values and philosophy issues. I think the term "wellness" is one that is used and begins to capture at least a values issue that we would like to see, but then that needs to be translated in a way that can be communicated to all kinds of health care activities, whether those are prevention or treatment in a model.

To me, the two types of things that can lead to

more specific things that deal with wellness are the area of health support and health promotion. Those are particular activities. We heard a number of examples of those over the last couple days. Health support is a particular set of activities, health promotions or types of interventions that are different than treatment, or at least different than interference, and that these should be the basis for both treatment and prevention.

It is going to be extremely difficult to get data on prevention. However, if you use health promotion, if you look at health promotion methods for treatment, that can give you at least some indications of prevention and treatment as an integrated phenomena. This is why I suggested before we not just look at cost effectiveness, but cost benefit because it brings in the value issues.

There is going to be a big dilemma. Then we saw many of the contradictions here in the last couple days between wants, needs, and behaviors. What are patients' wants? Well, they want good care, they want a massage, they want somebody to pay for it.

What are their needs? Maybe they need to have

some food. Those that do not have access to even standard medical care, health care is way down on the list. I mean, it is not a value for them. Yet, they may need those other types of things. There may be behavioral changes we need to implement to try to treat people in a health promotion that they want fast food medicine and this type of thing because that is delivered. That is something that will have to be dealt with.

All right, now I am getting to the word. The word is "accountability." I think we really should call this Access and Accountability, because if we don't deal with accountability, then we will not, in fact, get buy-in from those that control the power to current access.

Accountability includes accountability of care and services. Many of these practices, the way they are delivered do not deliver good quality services. You don't get your PAP smear, therefore, when you need it. Accountability in terms of products, we heard about that before. Also, accountability in terms of information. Where is the data that shows that this is actually going to work.

I don't mean to pick on chiropractors, but does subluxation help your wellness? Does it prevent disease? I have never seen any data on that. Okay, maybe we have some.

So I think access and accountability really need to be paired if we want to see things move forward. We need to bring groups in if we are going to be saying, what are the accountability standards that are going to have to be met, because if we don't do that, we can make all the recommendations we want, and those will continue to control the power.

DR. GORDON: What groups are you thinking of, Wayne?

DR. JONAS: Well, I think Charlotte mentioned some of them, and you mentioned some of them, the American Medical Association, HCFA, the individuals that control the actual delivery services. Perhaps, we will do that subsequently.

DR. GORDON: Hopefully, we will be doing that.

Tieraona, Tom, Ming, Charlotte, and maybe Don. I am not sure.

DR. LOW DOG: I think that part of it was

actually dovetailing on you a little bit, because when we were talking about access and reimbursement -- we had this conversation last night -- if you have access to things, there is a difference. If you have access, does it have to be paid for?

I think those are different issues. They are related, but they are not necessarily the same. If a naturopath is licensed to practice in 14 states, there is a board that supervises them, there is licensure, there is four years of training, there is all of this, why is it illegal for them to practice in the other states?

You know what I mean? It seems like with acupuncture, most states allow it. And yet, with naturopathy, you are practicing illegally, basically.

I do think there is something to be said for access, people's right to choose who they want to see as long as there is accountability, there is an appeals process, there is somebody to complain to if things go wrong. All of those things should be in place, but I think that access is different than how much everybody is going to pay for.

Then it gets into the issue of, are we

disenfranchising groups, but I would say as the evidence becomes available, as it does become available, then more things should be included, but I am not sure that we should just include everything. And I can only speak for botanicals. I can only speak for botanicals, but I tell you when you review the research on botanicals, 95 percent of it is not really worth the paper it is printed on. It doesn't mean they don't work. It just means that the research is not there to really show that it does.

So I hope that this commission looks at access as having people the freedom to seek the practitioners they want as long as there is some type of accountability. That is their access and their right to choose. However, I think we want to be careful on the recommendations we make about reimbursement when there is little evidence that that works for a particular problem.

DR. GORDON: Great. Thank you. Tom.

DR. JONAS: Can I just follow one thing?

DR. GORDON: Yes.

DR. JONAS: Accountability, I think, should be universal accountability standards for the values issues that we start with. So that includes accountability for

caring/delivery or in caring/services. That should be applied irregardless of the modality of the health promotion system.

MR. CHAPPELL: Two points I want to raise. We have been encouraged to do more listening to the consumer. If you would like to have some focus groups, we can arrange that.

DR. GORDON: Like to have some?

MR. CHAPPELL: Focus groups of the consumer who is buying CAM services. When you come to Maine, for instance, we have built in groups that are consumers of this very kind of market.

DR. GORDON: I would like to have -- and this is something that we have been trying for, and we want everybody's help -- I would like to have more consumers here every time.

MR. CHAPPELL: Whichever way you want to do it, I think we need to be more intentional about it.

The other thought I had is, I would like to stop thinking about reimbursement for a moment, and switch it to affordability. One of the goals that I can imagine us having as a group is to bring -- let's work

with Wayne's two components of wellness -- let's bring health promotion and health support to the public in an affordable way.

Now, if you start looking at it that way, there are lots of ways you can begin to solve the problem, but it is putting the control back into consumers' hands. My concern about the discussion about reimbursement is that it is not in the control of the consumers' hands. So affordability is the language to use as a goal to try to get that.

DR. GORDON: Tom, if you have some suggestions about how to introduce that into the discussion about reimbursement as another perspective on the whole situation of the exchange of money, that would be great.

MR. CHAPPELL: Who do I work with on that?

DR. GORDON: Who do you work with?

MR. CHAPPELL: Steve?

DR. GORDON: All of us.

DR. GROFT: And then the Planning Group.

DR. GORDON: Yes. Just be part of the Planning Group.

MR. CHAPPELL: Okay.

DR. GORDON: Ming?

DR. TIAN: I think for us to learn for each professional society, we have so many things together. I think just like a textbook, for each one, you have the chapter. For Chapter 1, the first sentence, you have to tell what is definition. This is not quite clear yet. We seem to be including everything here, and we need clearly to tell what is that.

For instance, like Oriental medicine. Oriental medicine is a system. Let me share my knowledge with you, and my experience. First of all, herbal medicine is No. 1. In oriental countries, including China, 99 percent of the patients are people using herbal medicine and herbal remedies. They might need a recipe, they may not, but it is No. 1.

No. 2 is acupuncture. It is about 20, 25 percent of the people using acupuncture. Now, when we talk about Oriental medicine, at least I am confused. What are you talking about? Are you talking about the whole system, whole philosophy, whole approach? Or, are you talking more specifically?

In this committee we have to answer the

question more specifically. We can say, oh, this is Oriental, it is philosophy. Certainly, we want to learn good philosophy for each culture, each tradition, but as professional people we need to answer the question.

So just like in 1997, at NIH they answered the question regarding acupuncture: what is the definition of acupuncture; then, what are the data available; what we should go. The answers to three questions: where we are; where we are going; and how to get there. I think we can clarify this. We can ask each group, each professional to do their homework, including answer the questions I mentioned, if it is possible.

No. 2, I suggest that, if we could, as I mentioned, we should invite FDA people to come, as well as consumers, to sit and talk, because when we talk about herbal nutrition, a lot of these are controlled by FDA policy. If they don't join us, we can't go too far.

DR. GORDON: Thank you.

SISTER KERR: I would like a new listening from where we have just been. It pertains to what Tom said about liberation theology, and what Joe said. So it is a little bit different here, what I want to say, or try to

say.

Joe, I believe I understood you to say that CAM really was the diagnosis, a symptom as a result of the health care system not working. I want to say this. I think that is so, but there is another level. That level is that, because people are unhappy or out of relationship, which is what I think is healing, they get a symptom. They go to the traditional health care system, and there is no longer a priest there, there is no magic, there is no wizard, there is no healing. Even St. Augustin said, "The purpose of life is happiness."

So what happens is, we are, me, am looking for myself when I am looking for healing. Now, here is the practical implication along with the philosophical. If we are looking for ourself, and joy and happiness, and we are given only a modality, we have not accomplished the objective of the person who comes to us.

So now we are talking at the level of purpose and meaning. I think either we will agree with that as a group or not, but if we do agree with that as a group, that has big time implications and a statement. I mean, maybe Bill Bennett has got a lot to say. Maybe we need

the "Book of Virtues" in the waiting room. I think this is very important for us to examine. For me, it is very important.

Every modality, if it is acupuncture, if I stick in a needle and do nothing else, I don't think I have done a heck of a lot for healing. I think we will just be creating another system that is inefficient and doesn't get the job done. The question is, is that we are about, though. I mean, are we taking that on, are we taking that conversation on here; what is healing.

DR. GORDON: George.

MR. DeVRIES: We have talked a lot today about access. One thing I want to encourage, there are a lot of important aspects, I think, the Commission -- directions they can go, but one encouragement is that the issue of who pays, whether it is government, whether it is private health plans, insurance companies, one common thread there is licensure.

One reason I believe chiropractic has done well with HCFA and various state agencies, as well as private payer systems, is they are licensed in all 50 states. One critical issue we need to remember is that it is the

individual states, not the federal government that regulates the individual licensures of providers.

One critical things, I believe, the White House Commission can do is consider -- it is a monumental task -- but consider recommending licensing statutes for acupuncture, massage, naturopathy. I mean, if you look at these three provider groups, for example, acupuncture, the variation in licensing statutes between states is really significant, to the extent of where it is really a mixed model if you are trying to deliver acupuncture benefits in 50 states. The same with massage, naturopathy is only licensed in 13 states.

So is we were able to, the White House Commission, recommend licensing statutes based on what appeared to be strong models out there, educational curriculum, then in terms of those particular provider groups, I believe there would be a significant enhancement in access over time, giving those individual states a credible foundation to look to that they can act on, where they can enact these licensing statutes and create the ability to access benefits.

DR. GORDON: It is now 5:00. I have really

appreciated this discussion as well as the last two days. It is really time for us to close. I want to say just a couple things that I have heard.

What, Julia? You want to go on?

MS. SCOTT: No. It is just everybody is packing up, so I am saying talk fast.

[Laughter.]

DR. GORDON: Somebody very early said that we are really working at two different levels, or in two different ways which complement one another. One is that we are articulating the deepest principles of healing, and health care, and of living, and of our lives here together. It is wonderful to hear and feel the energy in this discussion.

The other is that those principles are going to help us to articulate specific kinds of recommendations. We are also clearly beginning to have some ideas about those.

I feel great about this meeting, about everybody's participation, about all of us working together, and of course about the work the staff has done to make this possible.

Again, I think clearly we are cooking here. We are working from many different ethnic traditions and many different backgrounds. We are really cooking and beginning to create this wonderful preparation, this wonderful stew that we are all about.

The Planning Group for this meeting. I received a transmission. The Planning Group for this meeting included Julia Scott, George DeVries, Joe Fins, Tieraona, Conchita, myself, and the staff, and with Joe doing a tremendous amount of the legwork.

[Applause.]

DR. BRESLER: Joe, on behalf of the Commission, I think we also want to thank you for an outstanding job of putting this all together.

[Applause.]

DR. KACZMARCYZK: Well, I can only, with all due respect, accept part of that because each and every member of the staff contributed an indispensable part of this meeting. Without one of those members, this meeting would not have happened. Thank you.

[Applause.]

DR. GORDON: Thank you all. We look forward to

seeing you again. Please participate in all the planning groups with us. Let's move it ahead together. Thank you.

[Whereupon, at 5:05 p.m., the meeting was adjourned.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE: White House Commission on Complementary and Alternative Medicine

HELD: December 4-5, 2000

were held as herein appears and that this is the official transcript thereof for the file of the Department or Commission.

SONIA GONZALEZ, Court Reporter