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WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

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Meeting on Training, Education, Credentialing and Licensing of CAM Practice

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Volume II

+ + +

Friday, February 23, 2001

12:30 p.m.

Hubert H. Humphrey Building, Room 800
200 Independence Avenue, S.W.
Washington, D.C.

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C O N T E N T S

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P R O C E E D I N G S

[12:35 p.m.]

Full Group Discussion

DR. GORDON: We are going to begin now. I want to say a couple of words about what is going to be happening this afternoon. What you see happening around you is, we are putting up the fruits of the small group discussion meetings that we have been having for the last day and a half.

The way we are going to be working this afternoon is each group, Groups 1, 2, 3 and 4, will be presenting about the three different topics that they addressed. Each group will, in turn -- 1, 2, 3 and 4 -- will all present first about undergraduate and postgraduate education, and then there will be a discussion among the whole Commission. Then we will probably take a few-minute break. Then we will have the presentations about continuing education and a discussion among the whole Commission.

Then we will take another little bit of a break, and then we will have a discussion about licensure and credentialing. Then there will be a 15-minute break,

and then there will be time for public comment, and we will ask those of you who have signed up for public comment to come and give us your testimony.

The ground rules that I want to just remind all of us about are these are recommendations regarding education, licensure, and credentialing that are coming out of the small group meetings. This time this afternoon, this three and a half hours, is the time for us to discuss those recommendations.

We are not making definitive recommendations at this point. We are going to bring all of the recommendations and all of the discussion together, and then we will come up with some recommendations that we will bring back to this entire group, and then we will discuss those and see where we are.

This is really a time to think out loud, to raise issues that are brought to you, that come to you because of the recommendations, and to discuss the recommendations. Everybody okay with that?

I know that one or two of the Commissioners have meetings that they have to attend, so they may be gone, or leaving a bit early, but the vast majority of us

will be here for this whole meeting, and most of us will be here, as well, for the public comment.

So let's begin with Discussion Group 1.

Discussion Group 1

DR. FINS: Thank you. First, I want to acknowledge the work of my fellow Commissioners, George, Effie, Joe Pizzorno, Veronica, and the excellent staff work of Gerri, who pulled a lot of this together before this meeting. We are grateful to her for that.

What we did was articulate a number of principles that we felt were relevant across the continuum for undergraduate, graduate, CME, and into the accreditation and licensure issues. I want to just go through that because we are going to track forward with those principles.

The first is that we believe that resources should be given to institutions of medicine for them to operationalize the articulated principles. We think it is better done within the confines of the medical schools, and the licensing boards, and the residency training programs and the like, that they do it within their own structures, and we assist them in that process.

DR. GORDON: Joe, excuse me. Your committee was particularly concerned with --

DR. FINS: Conventionally trained physicians.

DR. GORDON: And each of the committee chairs, if you could state the domain that you were working with when you begin talking, that will be helpful.

DR. FINS: Secondly, we do not favor mandates, but we favor encouragements and activity that would incentivize behaviors and practices that we endorse.

Thirdly, we appreciate this is an evolutionary process. It is going to take time to change the culture of medical institutions, and there is going to be a time frame for that, and it is not going to happen overnight, and we want to foster mechanisms that will allow this to progress. We articulated a number of basic principles that we want to articulate that I think is true for the undergraduate, graduate and CME context and also for the those who regulate medical practice.

First, is we feel that conventionally trained practitioners need to have a minimal knowledge base or a core competence knowledge in CAM to provide competent medical care. We believe that these include the

fostering of communication skills that allow for the promotion of trust and open dialogue with patients. We think there should be unconditional acceptance of patients, but not necessarily of their practice choices.

So we have to hold patients in high regard in a way to allow the doctor-patient relationship to thrive. We believe this is important so that patients will clearly disclose, as they often do not now, currently, the use of CAM modalities, and this will allow for two possible things to happen: One is the optimization of therapy, and the example that we were thinking of -- and these charts are just beyond my visual threshold so I am straining here. I usually don't look like I have exophthalmos.

[Laughter.]

DR. FINS: But it is optimalization of therapy. So if a patient came in and disclosed that she were using glycocyamine, you might then discover she had arthritis, and then you might determine that perhaps she might be better served, if it was severe enough, to have some other modality like a Cox-II inhibitor.

The other thing is that the purpose of this is

also to identify drug-drug interactions or CAM-drug interactions and the like. We think that the education of students and practitioners should really start with the knowledge of the public health dimensions of CAM, the degree of the issue, and also -- it is getting smaller.

SISTER KERR: Do you want me to bring this up?

MR. ORNISH: Do you want to sit here?

DR. FINS: Yes, if I could. That would be very helpful, Dean. Thank you very much.

The second element here is that CAM is often an element of cultural practice and cultural expression, and there is a burgeoning interest in medical education about cross-cultural issues, and we think that is very important.

We think that the central elements of education could be broken down into categories of efficacy and safety. Joe Pizzorno came up with the notion of regulated practices which would move towards communication and collaboration, and then perhaps unregulated practices, which would require an element of surveillance to make sure that people's medical care was comprehensive and managed appropriately.

Additional areas that might be included in medical education is the kinds of practices that exist, their scope of practice.

A fifth area that we think is important is the scientific base of CAM and emerging research methodologies. If we help to build that kind of integration between traditional and CAM practices, at least in the conventional medical arena, the scientific basis of this is going to be very important. So we want to train medical students and our trainees to have the skill set to make that kind of collaboration. We heard a lot at earlier meetings about how the research methodology wasn't there, and we need to work on that.

The sixth was fostering collaboration between conventional and CAM practitioners and, seven, there should be opportunities for supplemental education.

Now, if I could just go quickly to the undergraduate area. Those are general principles. In the undergraduate medical context -- that is, the four years of medical school -- we identified several things that would need to happen: one is resources for faculty development, for curricular development, such as the AAMC

project or the NBME process to create board exam kind of questions and that support for this could come from the public sector, through HRSA, NCAM, Public Health Service, CDC, private foundations and other sources.

Additional areas that were needed to be developed and fostered beyond the excellent textbooks that are written by some of the members of this Commission, and you know who you are, but the National Alternative Medicine new journals.

We want to also foster collaboration within medical schools with established CAM professional organizations and accredited CAM institutions for both curricular development at- large, but also for local faculty support.

The example that we were thinking is, if a medical school, say, in Boston wanted to bring in a naturopathic practitioner, they might contact Bastyr University and find out who a graduate from their institution was in Boston and develop that kind of collaboration because the faculty resources may not exist in the conventional medical school to do this kind of teaching.

On the second issue of this communication and trust issue is we think that the incorporation of CAM issue should be incorporated into established doctor-patient communication classes, medical ethics courses on professionalism and also on history and physical exam kind of work because there may be specific issues that need to be brought up in the context of the history and physical that are not being taught currently in a traditional context; also, inclusion in a public health curriculum as a way of bringing in these other issues, pharmacology and herbals, cross-cultural issues and ethics and other areas; again, the scientific base of medicine into basic sciences, into the problem-based learning; also, importance of methodology; and, at the undergraduate level, appreciation of the interdisciplinary nature of CAM medicine and the professional collaborative skill sets that are necessary to make those kinds of connections, again with an eye toward patient safety;

And then, seven, the medical schools should be encouraged, have advanced or supplemental electives for students on collaboration, modality training or research

that would move beyond this basic core knowledge that we think is important, whether one endorses CAM or not, is important for the public safety.

Now, moving onto the graduate level, we think that there should be mechanisms to work with the RRC, the ACGME to develop support for specific minimal competencies, especially in the Primary Care Residency Review Committee, especially the primary care areas, where the interface with CAM would be more significant than, say, in some of the specialty areas, to find out what would be the core knowledge base that residents would need to have, what kind of offerings residency programs would offer to bring them up to speed for eligibility for their boards and the like.

We also think that there should be some mechanism for rotations with accredited CAM residency programs or teaching clinics so that residents who were interested could take time out of their residency training program and have this supplemental experience.

Also, we think that there should be some discussion about humanism in practice and competency for fitness related to, again, this unconditional acceptance

of the patient's choices, not necessarily an endorsement of the practice, so that practitioners would not be judgmental of their patients and be able to help them through their needs; again, further development of the history and physical skills related to CAM; training for interaction with CAM providers who might be in the community; very strong encouragement at the residency and fellowship level for research training experiences and fellowships at the NCI, NCAM and other bodies maybe to be established to develop the infrastructure for those who would advance the field; and also research should not be limited to the biomedical scientific dimensions of CAM, but also the operational delivery systems like Health Services Research, HRSA, systems of organization of care.

We talk a lot about traditional providers speaking with CAM providers, but what is the optimal mechanism, and how should that communication occur, and what kind of information systems should there be? But there is a whole new kind of information that needs to be established so those fellowships could be in the care domains.

That is basically the scope of our

recommendations, and I could say briefly for CME, because there is really not a lot to say, I will say that later briefly.

[Laughter.]

DR. FINS: So that is it. Thank you.

DR. GORDON: You are welcome.

Group 2?

Discussion Group 2

DR. WARREN: Group 2 deals with the licensed professionals, both traditional and nontraditional, excluding chiropractic.

After much discussion, we decided that the undergraduate curriculum should be of a world view of healing, world view concept of healing, including the philosophy and the principles of CAM, but with an experiential component -- we want them to experience this effect before they move on -- from a diverse perspective and be included in all centers of education, all centers of learning.

At the graduate level, we want the schools to be encouraged to include CAM, CAM concepts and principles. If we look at CAM skills that are

appropriate for each profession and a basic knowledge and foundation to make an appropriate referral, know when you have hit your limits, know when it is past your scope of practice.

In the continuing education field, A, we want all sponsoring organizations will approve --

DR. GORDON: Let's come back to continuing education later. That way at least we have some --

DR. WARREN: I will grab my tongue there, okay.

The next one is the national credentialing exams should include CAM questions that reflect a broader view of healing.

There are five. Primary practitioners' liability coverage. We talked about the malpractice thing. Liability coverage for the primary practitioner should include and cover referrals to CAM practitioners. Provider groups should develop their own certifying standards.

DR. GORDON: Let's see if we can separate these a bit.

DR. WARREN: Oh, you want me to do less than that.

DR. GORDON: Yes, so we can focus on undergraduate and graduate education.

DR. WARREN: Okay. Curriculum should not be limited to evidence-based outcomes theories and skills, but they should also include a risk-benefit explanation for each modality explained; possible ways of producing incentives for inclusion of CAM in curriculum.

COMMISSION MEMBER: Did you say "should not be limited"? I didn't hear you.

DR. WARREN: Curriculum should not be limited to evidence-based outcome theories and skills. This is to provide a latitude to at least look. If you restrict, restrict, restrict, you can completely constrict the view field to myopic. Whenever they give a skill, or whenever they talk about it, they have to give the risk-benefit explanation for each one of these to the including of CAM in the curriculums, questions on the national boards that would induce some of that, reduction in school insurance premiums.

Their faculty is going to take this course. They will reduce their premiums on the health insurance for the faculty members that the school has to pay;

community partnerships, corporate sponsors, private donations and foundations; reduction of future health insurance premiums for persons who have completed the basic course in CAM because it carries over to an entire lifetime; decrease in the cost of student health services provided by the school on site; research grants, NIH or whoever else gives out research grants.

We will hold off on the rest of it.

DR. GORDON: Great. Thank you.

Group No. 3?

Discussion Group 3

DR. LOW DOG: Group No. 3. Ming is not here today, but he was part of our group, and George, Wayne, and Dean, and myself.

Our group's task was physicians, nurses, pharmacists who do integrative health care.

DR. GORDON: No. 2. Don, who were the groups you were dealing with?

DR. WARREN: Nonphysician, conventional.

DR. LOW DOG: So our group has similar comments to some of the other ones that have been presented, especially with No. 1 because there is an overlap. We

are talking about, basically, in the undergrad and postgraduate, similar training because these are Western-trained practitioners.

As our first recommendation, though, we wanted to have undergraduate and postgraduate students and residents exposed to opportunities to learn, experientially, methods and practices for self-healing. We actually feel that this is the core of many of the CAM, and also conventional. In our ideal world, this is what we are wanting to talk about, is the self-healing that we all possess, and we don't feel that physicians or nurses could effectively counsel somebody if they hadn't experienced it themselves.

So those were broken up into good nutrition, and actually what constitutes that; exercise; stress management, which would include things like meditation and mind-body -- stress management seemed a little less controversial -- communication and social skills, and then, compassion and social service.

So that, again, we are talking about, in similar ways, how do you communicate, how do you communicate with patients, how do you communicate with

self in relationships. So, again, we just felt that this was essential that students have that experience so that they experience it themselves.

Then I think our next recommendation is, again, similar. It was that, health practitioner education programs should include an introduction to the philosophy, practices and principles of the most prevalent complementary and alternative health care modalities and self-care techniques, which we did include for self-care, and how to critically evaluate the safety and efficacy.

We would recommend that be done early in the educational process. With that, we are not really talking about evidence-based here. We are talking about an overview that introduces students in Western-trained schools to the world belief, the philosophy, the uniqueness of each of these modalities, so that they have an understanding and appreciation. We are not saying anything about, does it work or not, but, this is what is out there. We had recommended that the NIH categories, or seven categories, sort of be used as a template for schools to know what they should be covering.

We believe that complementary and alternative health care practices and modalities should be incorporated into established courses, where relevant, which is, again, a sort of, along with what Joe's group had said, pharmacology-practitioner, patient communications, evidenced-based medicine course, and obviously, cultural competency, as many different cultures practice their own traditional systems of medicine. So wherever those are relevant across the country, where needs might be different.

Then we had providing opportunities to be exposed to CAM practices and self-care during the clinical years. So opportunities for electives throughout that time, which also could include a month of self-care and self-healing exploration, as well as going to an acupuncturist's office.

CAM education. We recommend it should be evaluated using their current methods of testing and evaluation. The reason we made that comment was that we just felt that there needs to be some accountability on the school, also to be making sure that they are evaluating the programs and that students actually are

learning. We would suggest that they just use the tools that they already have in place for evaluation of student skills and learning.

The federal role. We also believe that there should be funds set aside through the federal government, as well as private groups, that would be able to fund and support these new changes in curricula, and also faculty, because nobody is going to rob Peter to pay Paul to make this happen. So there is going to have to be money coming in to make this happen.

And then, I think we want just to, again, encourage the pathways that are already in existence, and hopefully create more. About pathways, we had one there, like the school in Tucson, Joe Helms' course and other acupuncture schools, that we would encourage that Western-trained practitioners have the opportunity to pursue more in-depth training or overview courses as they continue. So a lot of similarity and overlap.

DR. GORDON: Thank you, Tieraona.

Group No. 4?

Discussion Group 4

MS. LARSON: Thank you, Buford, Tom, and

Conchita, for helping direct my attention.

This group dealt with the categories of nonallopathic, which included energy healers, massage, Reiki, polarity, yoga, chiropractic and naturopathic physicians. Out of that we had a request for about 39 papers or testimony, and we got 39-plus and a return rate of about 85 percent. So we had, overwhelmingly, the most information to go through.

I am going to read the question and --

DR. GORDON: I am sorry. This may be something that we should tell the audience about too.

MS. LARSON: Yes, I did some stats on return rate of all of them.

DR. GORDON: Linnea, do you want to say the kinds of organizations. For each of these discussion groups, we solicited input from a number of different relevant organizations, and that is what Linnea is referring to now.

MS. LARSON: Yes. The organizations and our return rate from our requests was 89 percent. So we had a great interest, on the part of the consuming public and the experts, in this particular area. I really want to

make a comment about that. Thank you, all of you who responded, and really helped direct our answers to the questions. So I am going to read the question and then refer you to our chart.

Question No. 1 was should there be national education standards for CAM modalities and therapies? And we answered an affirmative yes.

If so, how and by whom should they be developed?

Tom, do you want to help me on this one?

MR. CHAPPELL: We deferred, in this case, to the professional associations working in collaboration with the educational institutions.

MS. LARSON: And should those standards for a given modality therapy include exposure to other CAM modalities and therapies?

Conchita?

DR. PAZ: Yes. We definitely said yes.

MS. LARSON: And if so, how and by whom should that be determined?

Again, we went back to the professional organizations and educational institutions for that

determination.

Should those standards also include exposure to conventional or Western medicine?

Buford?

MR. ROLIN: Yes.

MS. LARSON: Yes. And if so, how and by whom should that be determined? Again, we refer back to professional organizations and national institutions of education, and we added another piece.

Tom?

MR. CHAPPELL: We have added the idea of the care navigator that was raised in a presentation by Richard Miles, which is to say that there is an emerging professional role of someone who is let's say not trained to be a physician, not the same requirements as a physician, but is trained sufficiently in the knowledge of all of the modalities and can function as a referring party to any one of the physicians or one of the therapies/modalities of CAM.

MS. LARSON: And we wanted everybody to be directed to look again at Richard Miles' description and to perhaps share with us any other thoughts on that

notion.

To Question No. 2, which is should there be scholarships and/or loan repayment programs for CAM students or students of emerging professions? I think that took us about 30 seconds, and that was yes, both.

And No. 3, Buford, I am going to read it, and you can answer. Should there be a minimum level of postgraduate training for nonallopathic and nonosteopathic physicians, such as naturopathic physicians and other unconventional physicians? Did I skip?

MR. ROLIN: I'm No. 4.

MS. LARSON: Oh, yes, you are No. 4.

Conchita, we set a minimum level.

DR. PAZ: Yes, we determined that we did want a minimum level, but again, part of it is we are going to be having the organizations determine that.

MS. LARSON: If so, how and by whom should that be determined, as well as how and by whom should this postgraduate training be created, structured and funded? Created and structured, again, back to the organizations and the educational institutions.

We also want parity in funding with emphasis, and I tip my hat to Tom for this, equal access and equal rights parity in funding for nonallopathic and linked with a federal coordinating office or body. So the creation of a federal coordinating office or body to the --

Do you want me to read No. 4, Buford? I will read it, and you answer it, 4 and 5.

Should there be use of the designation "traditional healer"? If so, how and by whom should traditional healer status or designation be determined?

MR. ROLIN: And our answer was yes, and the reason for that is that in our culture, traditional healers is certainly the most appropriate term applied. And I use the analogy for our audience who is here only the John Wayne movies and most recently "Dances with Wolves" did they refer to us as traditional medicine men, but we refer to our healers as traditional healers, and we would prefer that that term be applied, especially for the Native American and Alaskan Native.

Also, we noticed that that term was also commonly referred to with the Hawaiian Natives as well,

and so we felt like other healers within the community would certainly be receptive to that term as well.

MS. LARSON: Question No. 5: Should traditional healing be preserved and perpetuated? And if so, how and by whom should that be done and funded?

MR. ROLIN: In the case of the traditional healers for the American Indian-Alaskan Native community, we are talking about a very sacred situation here, sacred in the sense that we are taught from youth up and to the present culture the traditional healers that are today, even though we noted that in the model that was presented to us from the Native Hawaiian, how the system is with them, but our culture, the Native American, we look at traditional healing in the sense of the spirituality of it, and from that basis it is sacred. It is not something that we feel like we could -- there is no formal education for it, and we noted that within the same, with the response that we got from the Native Hawaiian.

How should it be funded? I know I used an example within the present law, Public Law 93-437, which is the reauthorization of the Indian Health Care

Improvement Act. I co-chair that committee. What we have asked for that, certainly, because our current director of the Indian Health Service, Dr. Trujillo, has supported us in that process as well, that there should be some funding for traditional healers, but the community should determine how and if that is to be paid because normally there is no fee for service, but we do also have established in some of our public health hospitals, if a patient so chooses to use traditional healers, and they can incorporate Western medicine in as well.

Those are the comments that we had regarding that aspect of it.

DR. GORDON: Terrific.

MR. CHAPPELL: Just one more clarification, and that is this idea that was mentioned on graduate work for residency, that we have a forum and create a CAM with the Department of Health. We actually saw that as a mechanism in all of the responses on undergraduate and graduate standards, as well. It would be a coordinating/facilitating office, not one with regulatory --

DR. GORDON: This would be at the level of the assistant secretary for Health or within the Bureau of Health Professions?

MR. CHAPPELL: Secretary --

DR. GORDON: At the highest level?

MR. CHAPPELL: Yes.

DR. GORDON: The highest level, okay. Thank you.

Commission Discussion

DR. GORDON: That is it for the reports for the four groups on this area. So we will open the floor for discussion about any or all of these issues, either points of clarification, if you want to expand on any of these points that you made in the summary or questions to raise.

Don, go ahead.

DR. WARREN: Joe, when you first introduced this, you said that you felt we needed to respect the patient, but not to respect the patient's choice of practice?

DR. FINS: No. We talked a lot about this, and I want to be clear. We want to have unconditional

respect for the patient, even if we do not endorse the practice that they have chosen, in order to have a trusting and collaborative kind of dialogue with the patient. If a person comes in and says they are using a certain modality, and you are dismissive or you are angry because they have veered outside of a certain domain of traditional medical care, you probably will erode that relationship, perhaps not find important historical or clinical information, and that would be a disservice to the patient.

DR. WARREN: What you are trying not to do is disenfranchise the patient.

DR. FINS: Right. Exactly.

DR. GORDON: The way I want to have this discussion proceed is if there is an issue that is raised, if you have a comment on this particular issue, then please raise your hand and make the comment, and if there are no more comments on the particular issue, we will move on to the next one.

So any other thoughts about this particular, and I think very important, issue that Joe's committee raised and Don just asked about?

[No response.]

DR. GORDON: Okay. And one of the things that we might think about, although this doesn't have to be definitive, is this the kind of issue that people generally feel is important? I am getting a sense of "yes." Okay. Great.

Other issues or questions about any or all of these reports?

DR. LOW DOG: Question about scholarships versus sort of loan repayment. Did you clarify exactly which modalities you felt loan repayment -- did you get that far? I might really love crystal gazing, but should that have a loan repayment? Did you get into that at all?

MS. LARSON: No, we did not parse through practice-by-practice, modality-by-modality. We looked at the question should there be scholarship and/or loan repayments for these practices? Yes.

DR. GORDON: And that is as far as you got?

MS. LARSON: Uh-huh.

DR. GORDON: Would you like to go a little further? Because I think the more discussion we can have

here, the closer we will be coming to recommendations.

Tom, go ahead.

MR. CHAPPELL: We have been impressed, throughout our discussions, with the high quality of the individual professions, the work that they had done within their associations to establish a standard for themselves. Most of these standards came from organizations or associations that have been involved for years as an entity. So, over time, as a professional group, they have honed their self-image of what they think they need to be considered credible and efficacious.

Our response I think on scholarships is that that is an educational institutional avenue and option. Whereas, the loan would be open to anyone. That might be government funded, whatever, but that would be more broadly offered than the scholarships, which would be institution-based scholarships.

DR. LOW DOG: I'm sorry. I misunderstood. I thought it was loan repayment. Scholarships and loans, I thought I heard--

DR. GORDON: Why don't you turn on your

machine.

DR. LOW DOG: Did I hear that wrong? Is it loan repayment or is it loans? The issue, if I go to school and then I go work in an underserved area, then a certain amount of my loan gets paid back. That is a loan repayment, and I probably misunderstood your comment.

MS. LARSON: No, you didn't misunderstand it. It is explicit. It says "loan repayment." We answered the question, should there be scholarships and loan repayment for these practices? And we answered it affirmatively. We did not say the mechanism by which those loan repayments. The loan repayment system, as you and I know, has to do with approved categories of practitioners, and that is settled in another forum.

DR. GORDON: What I'm wondering is, is your feeling that there should be loan repayment for these other practitioners if they serve in underserved areas?

MS. LARSON: I think that that is the implication of it, but that is, again, to be decided by opening up who can practice.

DR. GORDON: I am not sure I understand the distinction.

DR. WARREN: Well, what if it is limited to licensed providers of any type? If there is a licensing statute, then that qualifies them for loan repayment of loans in the first place.

DR. GORDON: This is a discussion, so it is really open to everybody.

Joe, go ahead.

MR. PIZZORNO: My normal inclination is to look at these as limit them to licensed providers because you have educational standards and practice standards, et cetera. The challenge with that, however, is that traditional healers that come from Native traditions, for example, don't then get included with that. So how do you both respect a culturally appropriate healer in this process, as well as a formally trained practitioner? I think we have to recognize both pieces.

DR. GORDON: Tom?

MR. CHAPPELL: In the inquiry we had on that subject in Seattle, it was clear that the traditional healer was someone selected by the community and that they did not expect reimbursement for their gift; that is, their gift of an ability to heal. So I don't think

that is a particular modality that is looking for access to funds or forgiveness of loans.

DR. GORDON: Buford, do you have any thoughts about that?

MR. ROLIN: Well, all I was going to add is the fact that, as we said, it is a gift. However, with the reauthorization of Public Law 437, which is explicitly dedicated to health care for Indian people, we have broached that subject and then included it. I am sure when the Congress takes a look at it, they are going to raise some similar questions, at least to find this specifically, but at this time that is the way it is handled, and certainly we wouldn't say that should apply, other than the American Indian community.

As far as the Native Hawaiians, I believe they spoke specifically saying it is gifts and all that they receive, as well, for their service.

DR. GORDON: So, any other thoughts about this? It sounds like we are moving in a direction of a general recommendation for scholarships and loan repayment for service in underserved areas for CAM practitioners, as well as -- and this comes back to, Don, I think it is

your group -- this also applied to conventional practitioners who were not physicians, other than --

DR. WARREN: You are looking at loan repayments?

DR. GORDON: Yes.

DR. WARREN: Oh, yes. Oh, yes. That helped me get through school.

DR. GORDON: Okay. Good. Any other discussion on this point? Incidently, this is exactly the kind of area and kind of recommendation that we may see in a very similar form in our final recommendations for the interim report. If you have questions, doubts, concerns, elaborations, this is a great time to state them.

So Tieraona, and Conchita, and George, and Effie.

DR. LOW DOG: I guess I was just asking for clarification on what we just agreed to because Joe and George had put forth licensed, so licensed massage therapists. Is that what we are --

DR. GORDON: Right. Yes. That is exactly what I was saying.

Conchita? Effie?

DR. CHOW: I want to bring up a philosophical part here is that -- Buford, please, agree or disagree.

In the Chinese medicine, until it became economic based also was, you know, you were the healer, a part of the village. Of course, it has become very westernized now, unfortunately, maybe/maybe not. But the American healer still has that concept; it is a spiritual healing, and they don't get reimbursed. I think we should think about this because I have worked a lot with the Indians in Canada, and here, and the different nations and so forth, and I think there are rumbles saying, well, we can't afford to just heal, in a spiritual aspect, and that it would be nice to have some reimbursement.

So are we in a position to put that kind of feeling out?

DR. GORDON: We are really talking about education now, not practice. So I would like to keep it to that dimension.

DR. CHOW: But education, you are talking about reimbursement --

DR. GORDON: No, we are not talking about

reimbursement. What we are talking about is scholarships for education.

DR. CHOW: Loans, scholarships, et cetera.

DR. GORDON: So reimbursement will come for traditional healers when we start talking about reimbursement in May.

DR. CHOW: What about their education when they are --

DR. GORDON: This is about education, yes.

DR. CHOW: That is what I am trying to move into too. If they spend their time educating, learning, shouldn't there be funds? I am just throwing this out.

MR. ROLIN: Our traditional healers are not professionally educated, normally. Some of them, today, they have moved away from the reservation, and some of them have moved back, and they are becoming more traditionally oriented. So, naturally, they are into more traditional healing. You have got to remember we are over 500 tribes, and that is key here, and every one of them is uniquely different in their culture. A lot of them are similar and what have you, and certainly a lot of them their traditions, and practices and what happens

within their communities and their particular tribe is culturally oriented from that tribe.

However, now we have had examples of where people have gone into our reservations, became familiar with the traditional healing practices, and have moved into larger cities and set up shops. So that may be the concern, and what you are saying there is it is a real concern of ours as well, and we know that has happened, but it happens with all modalities as well, but we are really concerned in that aspect of it.

DR. GORDON: Joe?

DR. FINS: Maybe Joe K. can help me with this, but it is my understanding that the ability for conventionally trained physicians to join the Public Health Service or do other activities to have loan repayment has been significantly decreased over the past ten years or so. I just would say that service in underserved areas is laudable, whatever kind of healer one is. So, if it has been eroded in the traditional arena and we establish it for CAM providers, we need to have parity.

DR. GORDON: Absolutely.

DR. FINS: But, Joe, I don't know, is there something you can add to that?

DR. KACZMARCZYK: The only thing I can add is some of the information that was shared by the National Health Service Corps prior to this meeting in that, (1) currently they meet probably less than 20 percent of the need using conventionally trained practitioners; (2) is that based on their experience, they would prefer to have someone in a loan repayment mechanism because it is much easier for them to take someone who is fully trained and place that person in a community when the community has identified what their needs are, rather than taking someone funding them through and then, at the conclusion, attempting to place them successfully.

DR. FINS: If I can just make one other point, it sort of resonates with the last meeting, is that we would want these people to be additive to basic health care and not an alternative to basic primary care for underserved populations.

DR. GORDON: Why don't you voice the concern behind the statement.

DR. FINS: Well, I would not want to have

underserved communities who were in need of conventionally trained practitioners getting CAM-trained practitioners because of some perverse incentive that we were creating. I would want them to have the full range of services that would be available to other members. There should not be a two-tier kind of health care system for the underserved.

DR. GORDON: Great. Everybody would agree that it is not either/or, it is both/and? Okay.

I think the issue of traditional healers is still a bit up in the air, but it may be because it is a bit up in the air. I don't know if there is a real clarification of that, at this point, that is possible.

DR. WARREN: I think you have to look at availability of practitioners. If you don't have an M.D. fresh out of school that wants to go to a town of 2,000 people in the Ozark Mountains, and you have got a complementary person that will come in, maybe a nurse practitioner or something like that --

DR. LOW DOG: Be a licensed provider.

DR. WARREN: Be a licensed, well, I don't think that --

COMMISSION MEMBER: Chiropractor.

DR. WARREN: Chiropractor is very capable. If that is the only practitioner in that town, that town needs him. They don't want to wait ten years to get somebody that wants to take a cut in pay to go to a small town.

Another thing we have to worry about, about the licensure thing, not all professions are licensed in all states. So, if these people, like an N.D., they are not licensed in Arkansas, if they want to go to Arkansas to practice, and obviously it is underserved, even though they are not licensed by that state and maybe they are licensed by another state, they have to go to the licensed state.

DR. GORDON: Yes. I think, when we come back to licensure, I think we need to address some of these issues because I think we are going to have recommendations about licensure.

Joe?

DR. FINS: I think we are talking about man- and woman-power issues, and I think that one of the recommendations that maybe we would like to make along

these lines about loan repayment is to ask an entity like HRSA to say more about the distribution of practitioners, to study it more formally, to have a tracking data of what kind of communities are being serviced in certain ways because we don't have the data.

If there is a community that has no practitioner of any stripe, you might say, well, something is better than nothing, but we shouldn't, in this country, have communities that have nothing. There should be a requisite minimum. So we need to know about man- and woman-power distribution, and I think that would be a kind of recommendation for funding to whatever entity in the federal government could do this kind of sort of tracking work. I think that is just basic materials to track this.

DR. GORDON: One of the things that we are going to have to do -- Joe just passed me a note -- is that, when it comes time for legislative language, we are going to have to delineate which professions we are talking about. If we are talking about all licensed professions, then that is what we will be talking about, and we will have to list all of those licensed

professions, so I just wanted to get is that the general sense here that that is what we are talking about, all licensed, and understanding your concern, Don, that licensure varies from state to state.

Okay. Let's move on. Other issues or concerns about any of the recommendations? Yes, Tom?

MR. CHAPPELL: I would like to offer outside our group it was brought to my attention by someone listening to our group that not all professions are sophisticated and developed enough to have standards for education, and it was suggested that in that kind of situation that this office that we are talking about creating in the Department of Health, as a coordinating/facilitating body, that that office be a mentoring organization to the creation of standards as a resource to the emerging professional group. I thought that was a very good suggestion.

DR. GORDON: Thank you, Tom.

Other thoughts about the issue that Tom just raised? Effie?

DR. CHOW: Because we have been referring a lot to licensuring and credentialing, and there are a lot of

emerging and old healing practices that are not anywhere near, and we would be amiss in --

DR. GORDON: We are going to come to licensure in a little bit. We are talking about setting educational standards right now.

DR. CHOW: That still pertains to that, I think. I agree. That was one of my recommendations too.

DR. GORDON: Other comments on this issue?

DR. LOW DOG: Are we saying that all emerging, that they all have to have standards -- is that what you are saying -- of education? So, if I am out on the Navajo, we have to set up standards? Because that is not really the way it works there. I mean, you will never have that happening in traditional medicines, those kinds of standards.

DR. GORDON: Buford?

MR. ROLIN: Tieraona, you are not going to have that happen on the reservations. Now we have conventional medicine that is practiced on our reservations at the hospitals or the clinic, and we support the National Scholarship Corps because that is where we get a lot of our docs, pharmacists, whoever.

But as far as traditional healing, there will be no standards established, within the traditional, within our communities, and I can tell you that all of our tribes are opposed to that, and they would not have it.

DR. GORDON: I didn't hear the recommendation that way. I heard the recommendation is for those professions that are interested in establishing standards, one of the functions of the government office would be to help them to establish standards, not an imposition of standards from above, but a facilitation for developing groups.

MR. ROLIN: And that is exactly what our work group was commenting about, that we supported that.

DR. GORDON: Great. Joe?

MR. PIZZORNO: Buford, a question of you is a healer that is in a community, is that person in any way recognized by the Tribal Council or is it simply kind of a grassroots recognition?

MR. ROLIN: Our traditional healers are recognized by our Indian community, and those are the people they serve. They do not go beyond the tribe. They serve tribal members. For example, I know many of

you have heard about sweat lodges and things like that. It is very common today, and I know when I travel to other reservations, I am invited to participate in a sweat, but beyond that, I do not get into more of the traditional medicine and all of the tribe, as far as the healers and all, traditional healers are concerned.

MR. PIZZORNO: Thank you. I appreciate that. I am asking a slightly different question, and that is when you have a traditional healer within a tribe, does the Tribal Council of that tribe recognize that person as a healer or is that informally just done by the people that are there?

MR. ROLIN: It is done by the people. Here, again, it is strictly up to our -- we recognize who our traditional healers are. We identify them as such, but it is for our purposes only. We don't, in any way, recommend them because, here again, it is the basis of the tribe and the culture that is within that community that determines who utilizes those services.

DR. GORDON: Great. Thank you.

Other issues with regard, especially to the first three groups and the recommendations that were

made, which we really haven't, we focused on Group 4, and I am wondering about some of the issues raised for physicians, other conventional healers and for integrative healing, undergraduate and graduate training.

Joe? Wayne, is your hand almost up?

[Laughter.]

DR. JONAS: What I was struck by, actually, were two things: One is how similar many of the recommendations were across these groups, and I find that reassuring and quite remarkable. There were some differences; also, that a lot of the basic recommendations I didn't think easily fell in or it wasn't relative whether they were undergrad, grad or CME, they are all basic skills that are probably required at all of those levels. What actually goes on in all of those levels, of course, will be different for the different audiences, populations and levels of training, but that also was something that struck me.

One issue that you mentioned, Don, was that you did not think it should be evidence based, and we had quite a bit of a discussion in our group that dealt with licensed practitioners that were already incorporating

complementary and alternative medicine, and, Dean, who unfortunately isn't here now wanted to stick "evidence-based" in front of every single word almost and make it a separate breakout item that was emphasized.

So the issue of evidence and evidence based, which is a very sticky one and which cuts across all of these things, I think will need to be addressed in some way. Yesterday we heard really several discussions about the need to clarify what we mean by evidence based, in terms of a lot of people use the term, everybody believes that we should have data and science involved in this as a way of guiding us towards better or not so good practices and sorting them out, but the question is how to do that, and for what purposes, for which audiences and this type of thing still needs to be clarified and will come back again and again, and the research funding will come back on the information side, when we talk about what we are going to provide, as well as on the training side. So, at some point, that is going to have to be addressed.

DR. GORDON: Thank you, Wayne. I appreciate that. Maybe we can address, at least as far as education

goes, address some of that here, since it has been raised.

Linnea and then Joe.

MS. LARSON: No, you answered that.

DR. GORDON: No? Joe, go ahead.

DR. FINS: I think that this notion of evidence-based practice is going to have different valence in different communities. If we are talking about pastoral care and spirituality, that is an age-old question, and there is still no proof, and it is a matter of faith. So it is the wrong question to ask in that context, but in a medical school or in a conventionally situated context, I think the NBME folks, in their testimony, did a very nice job in saying what they are going to test is going to be evidence based, which I think is an indication of the importance of evidence-based information.

I also would just add it is not our theme right now, but evidence based also may have some relevance for reimbursement and for manpower. So I think this issue that Wayne is raising about what is evidence, and what counts as evidence, and what modalities of research lead

to evidence, and maybe sociologic research and not necessarily hard science research, maybe outcomes research versus mechanistic kind of research, is a question I think is not for now, but for some other time to discuss. It is a very important issue.

DR. GORDON: Don?

DR. WARREN: Well, I think really what we were talking about when I said this was the curriculum, not the licensure, not whether you can practice this, but the reason we said it was not limited to the discussion, that passing it out is not limited to evidence based only, that leaves you latitude to look at the outside, to look just slightly past the fringes of where you are, not to necessarily make this part of your practice, but in the curriculum allow for the development of thought patterns that may bolster it or may shoot it down, but you have to leave that latitude there.

DR. JONAS: Yes. We agreed with that, and especially in the area where we were talking about we want to introduce these topical areas to a broad base. What is the minimum level of knowledge we are talking about, information there, which has to include the

philosophy, the principles, and this type of thing as a requirement.

Where it gets a little more sticky, however, is when we get into the CME, and maybe we haven't addressed that, gotten to that yet, and maybe the division is good, is the whole area of what is going to be approved of by the professional societies, by the CME or CUE boards and this type of thing.

DR. WARREN: We also said that they had to explain. Everything that they started they had to give an explanation of the risk-benefit for that, as best they knew at the time.

DR. JONAS: Yes. I understand, but that is another term for we want evidence for it. So, again, that needs to be clarified as to what is meant by that.

DR. GORDON: One thing I want to say is I think that the point is an important one, the point that you are making that, in a sense, both of you are making about looking beyond areas for which there is what we would call anything remotely resembling hard evidence, and that that kind of curiosity is an important part of education of all health professionals -- I think we have that sense

-- understanding that it may or may not translate into CME or reimbursement for practices.

Joe, go ahead.

DR. FINS: I don't know if this falls under something that the Department of Education would do or if it ought to be in DHHS or not, but I think that coming up with a model sort of curricular content, a task force or whatever, that would fit into a medical school, that would fit into a dental school, that would fit into a chiropractor school, that would fit into CAM modalities.

In other words, the conventionally trained physician needs certain kinds of information to practice responsibly. The CAM practitioner needs certain knowledge about infection control or communicable diseases or to identify jaundice or whatever the issue is. I think that there is a need to develop some creative curriculum that could be interdigitated in a kind of modular fashion into schools without bloating the curriculum because I think there is a real educational challenge here. How do you put more into a container that has only got so much room? And that is, I think, an educational problem.

DR. GORDON: Let me say we have moved on. This is a new topic, in a sense.

DR. FINS: Oh, I'm sorry.

DR. GORDON: That is okay. I am just identifying that it is a new topic.

Are we okay with this sense that we want to, and we can decide how to explore it, that there is a focus both on evidence-based approaches, but then an openness to other approaches for which there may not yet be evidence, at least understanding in some way, and then I do want to come back to yours, Joe.

Tieraona?

DR. LOW DOG: In response to what you are saying, I think we want to be careful, though, in the language that we use for schools that may already be sort of skittish about this, about saying we are not going to limit this to evidence based. I think a friendlier way to say it, perhaps, is that we will discuss the level of evidence, which may be anecdotal, may be historical, may be a double-blinded RCT that --

DR. GORDON: I think that is helpful. Do people find that distinction helpful? I do. Great.

Let's move on to the point that Joe raised about, and this is one of the issues, sort of a fundamental question that we raised right at the beginning of the Commission, is not only is there a question of understanding of CAM that needs to be in conventional education, but what about the understanding of conventional medicine in CAM education? Do we want to say any more about that right now or any more about the kinds of programs or the ways that might, as Joe said, interdigitate?

Go ahead, Charlotte.

SISTER KERR: Well, mine is even a little more different, but I am wondering if CAM doesn't need to talk to itself about what it is.

DR. GORDON: Do you want to expound on that?

SISTER KERR: Well, we are talking about need to have something in the curriculum about CAM for conventional practitioners, and it is speaking really to the content of the CAM program. Just because somebody does aroma therapy or whatever they are doing, doesn't necessarily mean perhaps they have a conceptual understanding of what CAM is, if we know what that is.

DR. GORDON: Is that a question or a statement?

[Laughter.]

DR. GORDON: It is gnomic comment.

Are you suggesting that part of the -- let me just extrapolate -- are you suggesting that part of what should be in the curriculum is a discussion, a kind of clarification about what CAM is, that that is part of the teaching of CAM?

DR. FINS: You won't know what you need unless you know where you are. There is a taxonomy here from CAM and its panoply of activities to the traditional, conventional practitioner to sort of have a kind of integrative approach, which is, after all, in the Executive Order, is integrative medicine different -- depending on where you are, the elements of integration are going to be different.

So I think that people need to know what they are lacking, from their perspective, and I think that is a really fundamental question. It is may be clear what medical students lack, but we don't know what the traditional healer lacks. Maybe they are not lacking at all because maybe they shouldn't move beyond their

religious domain or their traditional domain. I don't know. But the question is we have to figure this out in a way that allows people to compensate for their weaknesses so that we can have a integrative system.

DR. GORDON: I would like to hear some more comments on that because I think this is an important issue and at least the staff needs direction in pulling in information about this.

Go ahead, Tom, and then Effie, and then David.

MR. CHAPPELL: Group 4 took the position that we needed national standards, but that we would look to the individual professions for those standards, and then it was amended by an outside comment that I raised just a moment ago, that if that profession hasn't evolved yet sufficiently to have standards that the office here at the Department of Health would help them as a mentoring organization.

We see the professional groups as, well, that they are the first source and in collaboration then with the educational institutions because there is a minimum expectation that we need to have, as an organization, as a CAM community. We are asking that that minimum be

stated by the professions, but then the educational institution may go beyond that because they are in the marketplace for customers.

DR. GORDON: Let me make a slight interpolation here, and then I will go back to the order.

MR. CHAPPELL: Am I speaking to your question?

DR. GORDON: Yes, you are, but I want to say something a little bit different, just to shed another light on it, as far as traditional healers go.

In South Africa, for example, where I have worked with traditional healers and where traditional healers are working together with conventional physicians, they have gotten together and decided together, not independently, what traditional healers need to know most obviously about HIV, but also about other conditions.

So I think that it is not something that the individual profession can necessarily do by itself because there are major public health issues that all of us face and that there may be a kind of, it doesn't necessarily have to be coercive, but at the very least, if you are going to function as a healer in a community,

if you are going to function as an acupuncturist, there is a certain amount you probably should know, as far as I am concerned -- massage therapists, as well -- what do you need to know in order to know when to refer? So it is the same standard as for a physician.

MR. CHAPPELL: Yes, but the educational institution, in our opinion, becomes the compiler of those expectations.

DR. GORDON: Yes, I understand.

MR. CHAPPELL: And the sorter of that into curricula.

DR. GORDON: I understand that. All I am saying is that the educational institution may or may not accommodate it.

MR. CHAPPELL: It is a good example you are bringing up, and in our system of having a coordinating office for CAM here, then that could become the provider of public health information.

DR. GORDON: All right. Good. Effie and then David.

DR. CHOW: Carrying through from Charlotte's comment, it still goes back to I think we are not clear

about what each person is saying when they say CAM, and we need to take a bit of time I think to have a working definition of what we each mean of CAM and come to a consensus because we can't keep saying CAM, when we don't know what each person means.

Are we taking the OAM definition of CAM? Because they have six categories and very well defined. Are we taking that or are we taking the other concept that everything outside of the purview of what is accepted in Western medicine is CAM, and that does leave it very broad, and then that means that we have to define it down and select what is important for us to address presently and yet give a global concept.

I think we are confusing ourselves, and we are confusing all of the issues not having that mission statement of what CAM is.

DR. GORDON: Okay. David?

DR. BERNIER: I think this may be a little stickier than any of us would like it to be. I think, in an ideal world, it would be advantageous for all CAM practitioners, as well as non-CAM practitioners to know more about it. How much do chiropractors know about

mind-body medicine or Ayurveda or other kinds of things? But if we make recommendations to include broad, general training in CAM for all practitioners, we have to worry about the parity issue because how much did Dennis know about what psychologists do? This is a little stickier issue that I think we have to keep in mind.

DR. GORDON: Agreed. And what are some of the suggestions or lubricants here? Joe?

DR. FINS: I think it is not so much to promote efficacy, but to prevent harm. It is a harm-reduction approach. So I think your example of HIV knowledge and infectious disease knowledge in South Africa is a good example, but we have to delineate, you know, some entity needs to delineate what the basic knowledge is. What are the dangers that attended to the risk that is related to the particular CAM modality that people should be aware of?

So someone who is dealing with herbal medicine may want to learn a little bit about pharmacology and may need to know something about those interactions. Someone who does acupuncture needs to learn sterile technique and about the needle is a vector for infectious diseases, et

cetera. So I think that some entity needs to look at what the scope of practice is and figure out the risks that are related to practice and where basic medical knowledge would mitigate the risk.

DR. GORDON: There are two questions: One has to do with basic medical knowledge, and that is generally done in the licensed professions at this point. The other is, beyond that, are there any issues, as far as knowledge that people should have, about other practices, particularly about conventional medicine among CAM practitioners.

So, for example, in Washington, D.C., I sat on the Acupuncture Board. Everybody needs to know and demonstrate sterile technique, but the question is how much should an acupuncturist know about general medicine? Do we want to suggest that --- Tieraona, go ahead.

DR. LOW DOG: Some of these issues have been dealt with like on the reservation with community health aides. These are not people that have had a lot of times even high school education. Many times they are women in the community that have been taught certain skills, and it is relevant to each practice, sort of what we are

talking about for each different modality, and I know that it has been very effective in dealing with diabetes out on the reservations.

These community health aides, there is a lot of material now that is available for teaching lay people basically how to identify sort of when people need more help than perhaps they are getting in their community, and some of those kinds of curriculums might be very interesting to look at for some of the CAM modalities because they are easy to teach, and they are already available.

DR. GORDON: And this goes back to Tom's point, that since we can't specify right now, if there is an agreement that there needs to be some consideration of basic understanding that all practitioners should have about important health issues, then we can think about how to make that part of our recommendations. Is that fair enough? Does everybody feel comfortable? Buford, do you feel comfortable with that, as well? I just want to check. Effie, that makes sense?

Okay. Joe, go ahead.

MR. PIZZORNO: I think that Joe made some very

important points here. Also, one of the reasons why I thought it was so important for there to be collaboration between conventional medical schools and accredited CAM institutions was not only to help educate conventional institutions about the standards and practice in CAM, but also it is a good way for the conventional medical schools to interact with the CAM institutions and help facilitate this flow of medical knowledge of a body of knowledge that is important for all CAM professionals to know.

DR. GORDON: Thank you. Charlotte, do you want to address this question as well?

DR. LOW DOG: I want to talk about definition of CAM.

DR. GORDON: Okay. You want to talk about the definition of CAM.

DR. FINS: Before you do that, could I just --

DR. GORDON: That is on the table, but let's deal with the question that Joe Pizzorno raised, and then we will come back to that, okay?

DR. FINS: I think that there are questions of what people need to know and then how do you

operationalize that in systems of care. So this is really a health systems question, and I think that this is precisely the kind of thing that HRSA does very well, and the Public Health Service does very well.

I think we are talking about an integrated health care system across all kinds of old boundaries. Patients don't respect the boundaries, but the disciplines are boundary driven, and so we have to promote this kind of exchange, identify what the information is and then develop a system for oversight. I mean, Tom's idea of some sort of central office is a possibility, but oversight, because I think that each one of these entities, whether it is traditional medicine or the CAM modality or practice or system of care, in isolation, can't do this because, after all, we are moving beyond isolationism.

DR. GORDON: I want to ask another question, back to Joe's, to the recommendation that came out in different forms. Is it the general sense that wherever possible, educational organizations should collaborate and develop these joint systems of working together and training together? This is something obviously that is

already beginning to happen, but just beginning to happen. Is that a general agreement? I just want to check with people.

Okay. Let's come back to the definition issue, then.

SISTER KERR: Applicable education, just to say when you mentioned the acupuncturist needed to know clean needle technique, the other question is how much does an acupuncturist need to know about Ayurveda medicine or some other modality within so-called CAM?

Many of us, I imagine, I don't think I'm the only one, got the letter from the ambassador from India, and it was such a distinguished and polite letter, and this person lists was it six established modalities of healing, and two of them I had never heard of, and I was so excited. I thought, "Girl, you have got a lot to learn." So I make that point.

The other thing is, in terms of the definition of CAM, and Wayne just said it, we do need a positive definition of CAM, and we have even hit on this -- well, we have hit on it on many levels, in my opinion, but even in terms of CAM, when we were talking about complementary

and alternative medicine; is that appropriate? Well, okay, diagnostics. Could we say therapy?

So we have a question at hand here.

DR. GORDON: Do you want to, in a few minutes, do you want to work on that question here or do you want to come back to that later on when we look at -- one way to do it might be, as we look at the early portions of our report, as we do a draft, and then have an opportunity for everybody to comment on it, and then have a much longer discussion about what CAM is at that point.

SISTER KERR: I think, unfortunately, when we had the task of today, and you know hindsight is always clear, we developed a curriculum for something we are not quite sure what we are talking about.

DR. GORDON: What I would say is that we spent a few hours earlier on in our deliberations talking about what CAM is. Clearly, and some people are saying, well, we still don't know what it is. Some people, at least, don't know exactly what it is, and maybe collectively we don't know what it is. So I see this as an ongoing and deepening discussion.

SISTER KERR: No, I meant that, too, in jest.

Because, on a practical level, I meant I do think we really almost need subgroup work on this because it is going to come into our depths, I think.

DR. GORDON: Okay.

SISTER KERR: I just was meaning we need the time --

DR. GORDON: So maybe that is an interesting suggestion, to have a group of the Commission, a subgroup work on this and work on this with conference calls, and then bring back your thoughts to all of us. Does that make sense. Effie, yes?

DR. CHOW: Yes, I have been pursuing this, and so I do agree.

DR. GORDON: Great. We might as well do this administrative piece now. Who would like to work on that?

Do you want to get the names down, Steve?

Wayne, good, all right. Charlotte, you are on this one, and Effie and Linnea. Terrific. That is great.

Okay. A few more minutes on undergraduate and graduate education, and then we are going to take a

little break, and then we will come back for CME. Other issues, and incidently, as Wayne mentioned, there are a number of areas that there is considerable agreement and consider that those will somehow be manifested in the recommendations, but other issues that are -- questions about your comments?

Yes, Linnea?

MS. LARSON: Just briefly. Charlotte, I don't think that we developed the curriculum. We developed, basically, as a group, that there ought to be some standards for, and then giving organizations and national institutions and spelling out those details, but I am loathe to develop a curriculum. I don't have the knowledge base, and I never will. I only have parts of the picture.

But I do agree, absolutely, that there ought to be standards, and I also -- this is a kind of statement -- I think, prefacing our group on what does CAM constitute, it is prefaced by a system of knowledge with a variety of modalities, and techniques, and principles.

DR. GORDON: Joe, and Tieraona, and Wayne.

DR. LOW DOG: We didn't develop a curriculum

either. Basically, when we had to address, though, what are the med schools going to teach, we just used, at this point, the NIH categories because that is what was available, and obviously we are flexible on that. That is what we used as a guideline, though, since it has already been done.

DR. GORDON: Joe, did you want to go?

DR. FINS: Yes. I just want to add I think it is not our place to write the curriculum, to micromanage the educational or academic experience, but we should encourage those bodies that do that to do so and give them resources.

I think, again, getting back to Tom's idea, if there is some sort of central repository, to have a kind of consortium of resources for exchange, whether at the federal level or some institute or something, that would be very helpful.

DR. GORDON: Great.

Wayne?

DR. JONAS: I agree. We did kind of give an umbrella and say, gee, here is a definition at the NIH for CAM things. However, I think then later, this

morning especially, we kind of backtracked on that, and we said, now, wait a minute, there are some core issues that everybody should know, and they cut across all of these terms -- complementary, conventional, et cetera -- and those have to do with healing and self-healing practices.

DR. GORDON: Right.

DR. JONAS: In our recommendations, we listed that, in our first thing, what we thought were some of the five core elements of that: appropriate nutrition, exercise, stress management, mind-body, spirituality, this type of thing, communication, and compassion, and service.

So our feeling was that these were core elements that both bridged the conventional and the CAM community, so they were core elements of integrative medicine. They should be known, regardless of what level of education you are at or what type of specialty practice that you are at, and there are also things that every good citizen should know how to take care of themselves about, so they cut across educational categories, as well as CAM categories. This might serve

as a beginning for coming up with a positive definition in these areas.

DR. GORDON: I think that is a very important point. Are we going to have a kind of consensus about those five categories, as those are being sort of central principles of our approach to CAM education or no?

Yes, no?

DR. JONAS: I would say integrative medical education.

DR. GORDON: Integrative education, fine.

Go ahead, Effie, and then Tom.

DR. CHOW: I don't know whether it falls into those five, but I think Charlotte again brought up an important aspect that energetics is what makes this different than just integrated medicine.

DR. GORDON: Tom.

MR. CHAPPELL: Well, to answer the question of whether the framework of five is all inclusive or not, I am personally finding it helpful to look at the University of Arizona's associate fellowship description of their curriculum, which is in Group 1, Tab -- I don't know what tab it is -- anyway, it is Dr. Weil.

The point is that the degree is based on foundations, elements, and then integration, and I just find it helpful to look at how a curriculum has been constructed for an internet degree, because it is new, it is trying to become integrative. It is not the only one that we would have for a model, but I think we need to look at models wherever they exist as a reference.

DR. GORDON: I think what I am trying to get at is more general, is the concept of self-care, self-knowledge, self-healing, and service, are those concepts viable concepts across the board as part of education.

DR. JONAS: Let's get it clear. The concept is really about self-healing practices, and then within those are a core set, and I think what you are asking about is are these the core set that we want to kind of put out or at least approximate.

DR. GORDON: Are these aspects, at least aspects of the core set, yes, if not the core set itself.

DR. JONAS: Right. There is a single concept, and then there are subcomponents. The concept is self-healing or health promotion, if you look at it from an intervention point of view, this type of thing.

MR. CHAPPELL: I don't accept the idea of self-healing, I really don't. It is health promotion and healing in some cases, and it is preempting disease through a maintenance promotion program.

So, self-care is far more descriptive than self-healing for me.

DR. GORDON: Self-care. Joe has got a problem. Effie is first, and then Joe.

DR. CHOW: I don't have a problem. This is a positive aspect. It would be very nice if each person, the Commissioners, would write in. They don't have to make it a literary piece, but put in the words that are most important to them and some concept that is most important, and I think I would love to see that, for us to get information, and then we distill that and then come up with a --

DR. GORDON: We did that actually earlier on, so everybody put in those words and those concepts, so that may be helpful to you as you pull together your definition. I mean people are welcome to do it again. I just want to point out that we have already done that.

DR. CHOW: I think we are in a different space,

though.

DR. GORDON: Okay. That is fine.

DR. CHOW: I think if they could now update this now. What do you think?

DR. GORDON: Effie, why don't you take that for your subgroup, if that is the recommendation you come up with, then, let everyone know, and then we can do that. Okay? Rather than do it as this moment.

DR. CHOW: No, not at this moment, but if people can send us these things now. Can we make that request of them, Wayne and Charlotte, if everyone will send us, e-mail us.

DR. GORDON: Let me make another suggestion. What I would like you all to do is to have some discussion, because you may want other things from the whole group, and rather than do it piecemeal, I would like you to come up with your thoughts and then come back to us and ask us for what you would like.

DR. CHOW: Well, I go the other way. I would like to get input, and we can get them together and then feed back along with our own impression, and then the second input from the group.

DR. GORDON: Let me just ask you, if you do it the other way, I just think it will simplify things, because you may well come back to us and want other things, and I think people have a limited time that they can go back and forth with discussions.

So if you would meet soon and tell us all the things that you would like from us to advance this discussion, I am open. If you want to do it the other way, I just think it is going to be so many e-mails crossing back and forth. It will be easier if you can meet on the phone and tell us what you need.

I'm sorry. Charlotte, go ahead.

SISTER KERR: I understand what Effie is saying, and I was thinking as well, and by the way, this was tasked to have the staff help us. We might have a good beginning to have right now to ask, not this moment to do it, just to ask that and let us have something to start with. It could be sent in to staff, who then could send it to us, just what is your definition of CAM, and then go from there.

DR. GORDON: Is everybody comfortable with doing that? Joe, go ahead.

DR. FINS: My concern, you know, with phrases like self-care is that if we are talking about a collaborative relationship --

DR. GORDON: Wait, let's finish the one issue and then come back to this one.

DR. FINS: Well, I am leading to this.

DR. GORDON: Okay.

DR. FINS: I think we are in a state of flux. We are developing something, a social movement, and we are trying to label what it is as it changes. A name implies, you know, a sort of static construct, and I think to some extent it is moving. I think that we are going to get bogged down in labeling, because it looks different from different places in the care continuum.

This group may say, define CAM in one way. People to the left of us and to the right of us will define it differently. It is a social phenomenon, and it is going to be hard to define.

I think it would be more productive to look at things, you know, practices, modalities, health systems within CAM at large, and use CAM as sort of a bookmark right now, and not get bogged down, because I think

generalization is not going to help us, but there are different problems for different aspects of the CAM modality, whether it is naturopathic, Chinese Medicine, Ayurveda.

I think that would be much more helpful, and I think that it could perhaps be perceived as being offensive to people who have been working in the public health arena and health promotion for many, many years.

I mean before there was Healthy People 2010, there was Health People 2000, et cetera. Health promotion is not necessarily the purview of CAM. It wasn't invented by CAM, it was invented, you know, by predecessors to CAM.

So, I think we might be doing a disservice to a lot of good work that has been done by trying to co-opt the good.

DR. JONAS: This is exactly the dichotomous type of thinking. What we are trying to do is look at an integrative aspect, and I see it a little bit differently. I would see it as a core issue that cuts across this, not as a co-optation of health promotion, but as an area of residence between complementary

medicine and conventional medicine in which they are talking the same language, and this is really the point, if you will, of integration.

DR. FINS: That is why I think the CAM definition is problematic and integrative is far more productive.

DR. GORDON: George.

MR. DeVRIES: Again, I will go back to, as we talked over lunch, which is to stay focused on the executive order, which is access, education, licensure, and reimbursement of CAM, which really relates to, as Joe was saying, it is the modalities, procedures, and provider groups.

I agree with you that CAM is very broad and includes self-care, but I am coming at it from the context of what is the Commission, what does the report supposed to have in it in the context of what are we supposed to be addressing.

From that context, it does narrow our focus. It doesn't mean that CAM is narrower than that, it means that our focus maybe is focused on the areas of access, licensure, education, and reimbursement.

DR. GORDON: Tieraona, then Tom.

DR. LOW DOG: Part of this is -- I agree the definition of CAM is very ambiguous and it makes it difficult when we are trying to do a task on what is it, but I think that there is something deeper that we keep walking around, which it is almost defining healing, self-healing, self-care, wellness.

We can't even come up with a word, yet, we all know what we are talking about. There is something almost intangible. Maybe, Effie, you recall energy, I don't know how we define it, but there is something. So, we are talking about compassion, communication, nutrition. What does that all get you to? It all gets you to this underlying sort of premise about healing itself.

I think that is partly what is getting in the way here is trying to define the indefinable. I mean I don't know how we define it. I think that what we tried to do was our first recommendation.

Wayne had done a lot of work on this and thinking about it, and we all felt the whole notion of the self-healing organism or salutogenesis that we are a

homeostatic organism and how do we work to maintain homeostasis, how do we maintain that, that is part of the scientific approach to looking at holism and health.

I think our first recommendation was that we wanted healers of all kinds, physicians, healers, healers of all kinds to experience this, to experience these basic things about compassion and communication, and what it means to eat good food and to deal with your anger, and be in good relationships with people.

I don't know what word we are looking for, but that is what we felt was most important of all of this, and I don't think it is under the purview of CAM or anything else. I think it is under the purview of good medicine, and I mean medicine beyond just medicine. I mean good medicine is just sort of good relationship.

DR. GORDON: Tom.

MR. CHAPPELL: First, I wanted to bring to George's attention the executive order is all about the consumer movement and the public's accountability to a consumer movement by looking at it in terms of four categories.

You have already referenced the four

categories, but you didn't mention the whole purpose of this movement and why we are here, which is we are formed because of the consumer movement and our responsibility to serve that public better. That is number one.

This is a consumer-driven, consumer accountability purpose. That is why we are here.

Now, with regard to the question of language, healing versus care, self-care, the reason self-care has become a term that is particularly descriptive is because it is a way of describing authority. It is moving authority out of the hands of the doctor and into the hands of the consumer. That is why it came into being.

It is healing in the mindset of the consumers in many, but it is also being preemptive of disease. All I am trying to point out in both comments, that we need to begin to sit in the seat and in the shoes of why we are here, which is the consumer to whom we are accountable.

We are not accountable to the Acupuncture Association, we are not accountable to the DO's and the M.D.'s. We are here collectively to make sense of an emerging transforming, transitional medical paradigm. We

need to bring sense of this to the consumer and to the public, so that they can have access, better information, better services' standards, and that is why we are here.

I think we tend to lose sight of that, but it is right in the first paragraph of the executive order.

[Applause.]

DR. GORDON: Effie.

DR. CHOW: This is one of the reasons why I recommend that we get input from the people instead of five people, six people writing out what we think we have interpreted, and then we distill from that to come with an overall mission statement of what CAM is.

I would like to sort of nominate Wayne as kind of a chair of this group, and I would like to have Tom come into this group, being part of it, and we are happy to work together.

I really do, I really think it is important for you people to send in to staff your input as to what you believe CAM is, because everybody is saying CAM, and we are not sure what each person means by CAM. Thank you.

DR. FINS: May I make just a comment on that?

DR. GORDON: Go ahead.

DR. FINS: My suggestion would be to jump-start the process, and actually Charlotte suggested -- you suggested it initially, and she has supported it -- is that we all send in some of our own concepts and definitions and descriptions to the staff.

I think we will be happy to try to wordsmith it, look for commonalities, put it together in a concept that then can be shared, but really the whole group needs to be part of the discussion.

DR. GORDON: So, you would like that now.

DR. FINS: Yes.

DR. GORDON: I don't mean this moment, but I mean after this meeting. Okay.

Is that okay with everybody?

DR. CHOW: Next week, get it to the staff, and then get it over to us.

DR. JONAS: And everybody needs to do it or Effie is going to be on you.

DR. GORDON: I just want to check. Is that okay with everybody? Okay.

DR. CHOW: So, next Friday, deadline.

DR. GORDON: And would you like a deadline of a

week or so?

DR. CHOW: Next Friday, deadline, to get it to Michele, and then she will give it to us.

DR. GORDON: Effie, I would also suggest if we can have the staff send around, perhaps to all of us, an e-mail with the initial definitions that we have, because we did answer this question a few months ago. Of course, it may have changed, but I think that might be useful information, as well.

[Pause.]

DR. GORDON: Before we finish with undergraduate and graduate education, is there anything else or can we leave it and then move on to continuing education? Is everybody willing to leave this for now and move on to continuing education? Yes? Okay.

Let's take a 15-minute break.

[Recess.]

DR. GORDON: First of all, I want to thank everybody for the spirited discussion and both for the return to fundamentals, as well as addressing the issue at hand of undergraduate and postgraduate education.

We are going to begin now and talk about

continuing education. Let's have each group do a report on the subject, we will have a discussion, and then we will move on after that to credentialing and licensure.

Joe.

DR. FINS: We are just doing the CME now?

DR. GORDON: Just CME, yes.

DR. FINS: We wanted to just identify the first problem was that the traditional CME model doesn't really apply too well to CAM modalities because CME sort of presupposes building upon preexisting knowledge and competencies, it is continuing education, and in many regards this may be remedial and it may have a lot in common with undergraduate medical education because people have not been exposed to this in their formation, in their training, so that is just one issue.

The second issue was that -- Doris just put another pile of paper on here, so I can't find what I was looking for -- but I think it was the pediatricians or the family practitioners who would entertain CME credit for course work that had validation, and we urge and encourage those entities to give CME credit for accredited programs, and also establish a process to

assess threshold for which a program would gain credit.

Also, we wanted to say that there were avenues outside of CME for these things that perhaps wouldn't rise to the level of accreditation for independent physician study.

Finally, that there is a whole other range of activities which are really kind of professional training programs like Andrew Weil's program or taking a 200-hour course in acupuncture or fellowship programs that could be done for people who are in an established practice, who want to go back into sort of a graduate medical education mode.

But I think that the major point is that continuing education in this area is a little different than continuing education in other areas of CME, because the foundational basis is not there in many respects.

It seems to be right now that there is a lot more work in added competencies than continuing to maintain a competency.

That is sort of the gist of what we discussed. I don't know if George or Effie or Veronica want to add to this, or Joe is not here.

DR. BERNIER: Well, we really put our efforts I think into the undergraduate and graduate training. Actually, I guess one of the issues clearly is going to have to be that the accreditation would have to come from the discipline if we do it in a postgraduate setting. That is, the various programs that an individual would be getting is CME, and I think ought to be certified by the discipline that is putting that forth.

DR. GORDON: Certified by the CAM discipline?

DR. BERNIER: Yes, by the CAM discipline.

DR. GORDON: Great. Thank you.

Group No. 2.

DR. WARREN: We thought about this long and hard. All sponsoring organizations will be approving CAM offerings. We felt like that would put a little pressure on the organizations to stimulate CAM research, but also to stimulate the approval of CAM.

Sponsoring organizations will encourage practitioners outside of their focus group to take these courses and award them the appropriate number of continuing education hours.

DR. GORDON: Can you say what you mean when you

say "sponsoring organizations," can you define the term?

DR. WARREN: Well, you have got sponsoring organizations. You have got the American Dental Association. You have got the Academy of General Dentistry that -- well, I take it back. They approve continuing education courses by sponsoring groups.

A sponsoring group could be the Academy of Oral Facial Pain, the Academy of Pain Management, or any course like that or a school. The sponsoring organizations, as it is right now, focus the target group of their profession. They don't look at anything else. If you go to take their course, very seldom do you get continuing education hours for it, it is extraneous information.

So, by coaxing these groups to approach groups outside, we get a cross reference, we get to learn the other person's language. You know, M.D.'s have their own language, their own private handshake, and their own whistle. Dentists have the same thing, chiropractors have the same thing.

If we can transform this communication gap from my $10 words and your $10 words to a commonality, then,

that is going to help ultimately the patient, and by doing that, by allowing these other practitioners to come in to take part, to gain CE hours, and then to go back and apply them to their credentialing or licensing requirements, relicensure, recertification, get that in there and let them do it.

It is up to the states as to whether they allow those hours, but you can put the hours on your CE if you want to, or CV, and that is why we said allow those hours to be taken and counted and pursued to better improve the communication between the groups.

DR. GORDON: So, are you talking about cosponsorship of different groups?

DR. WARREN: It can come in the form of cosponsorship, it can come in the form of the dentist group inviting the chiropractic group in the local area to a course, or it could be the M.D.'s inviting the acupuncturists to a course in the local area. In that way, you have broadened that communication.

DR. GORDON: Okay. Great.

Group No. 3.

DR. LOW DOG: I think for Group No. 3 we echoed

a lot of Joe's -- I mean because we are still talking about the same group basically, but we still struggled with the issue of information versus skills in CME's, the two-tiered system, so one is coming and learning information, and the other is actually learning skills that you could go back and use.

I think we would like to work on some language that sort of addresses the skills where there is evidence -- skills is different than information, but I think where there is evidence that those skills, these groups should be more open to allowing physicians to learn these skills, so that they can actually take them back and utilize them in their practice.

The reality is many of our group, the integrative physicians or nurse practitioners, we represented all of them, they are already doing many of these skills, so I mean they are already doing them, so we would echo what Joe said about the basis, again, in the undergraduate, postgraduate, and fellowship programs, and then trying to expand upon what the AAFP and others look at for skills versus information.

DR. GORDON: Okay. Great.

Group No. 4.

MS. LARSON: I think I am going to read off the questions again, so we can get it very clear. We actually had four questions.

Should every CAM practitioner be expected to have a minimum level of knowledge and understanding of other CAM systems of care, modalities, and therapies? We said yes.

Again, if so, how and by whom should that be determined? Be determined by each organization or specialty within CAM.

Of what should that basic knowledge and understanding consist, and how and by whom should that be determined? Again, defined by that specialization or that practice.

Finally, we gave some more emphasis to kind of coordinated office that would act as a coordinating office and with the addition of kind of a mentorship.

DR. GORDON: I am sorry, with the addition of?

MS. LARSON: A mentoring for those organizations that would need help in systematizing.

No. 2. Should every CAM practitioner be

expected to have a minimal level of knowledge and understanding of conventional or Western medicine, and referring to conventional physicians or conventional health care providers, how and by whom should that level of knowledge be determined?

Tom, would you explain what we did?

MR. CHAPPELL: It is the same profile as the first question. We refer back to the professional association for that standard and that requirement. On the other hand, we still see a role for an office here at a national level providing any assistance where necessary.

MS. LARSON: And our third question is what is the role of continuing education for CAM practitioners? We spent quite a bit of time in this one. It is to enhance the learning and knowledge in an ongoing basis for all CAM practitioners, it is not static, it is ongoing.

Lastly, should organizations representing a given modality or therapy come together to form a community? If so, how and by whom should that community be formed? We had an awful lot of information again

given in writing and testimony on that.

Just the notion here, it is that many said we already have a community, and many said no, we don't want to have a community. Those people supposedly within our community, some members are not talking to us.

I mean this is important because we got a lot of information on that, so we discussed it quite a bit. Would you like to --

MR. CHAPPELL: Sure. Basically, we felt that we needed to respect the different perspectives within a professional organization, but that we needed to expect them to be in a dialogue to try to find their common ground. So, we see a dialogical community as being the way to define a profession that has different trade groups.

We reemphasized the fact that we think these groups are really self-determined, but we want to have a relationship with this office in Washington.

MS. LARSON: And with a wellness orientation. The end.

DR. GORDON: So, questions, comments, issues that are raised by these four group presentations? Joe.

DR. FINS: This may be a segue to the last part of the triad here, but jurisdictional issues. This may be a question for Tom about having sort of the central office, because generally, it is sort of the purview of the states, you know, so I was just wondering how that -- I mean sort of segue into looking at the regulation, but did you guys think about that, a central clearinghouse issue?

MR. CHAPPELL: We have felt that an office in Washington, a national office would be strictly coordinating, facilitative, referential, but not regulatory in any means.

DR. FINS: That's helpful. Thank you.

DR. GORDON: Okay. Other issues that are raised by any of this? Wayne.

DR. JONAS: We thought that the biggest disparity actually between our group and the other was in the continuing education group, because remember we were focused on those practitioners who had conventional licenses for the most part, but were now becoming holistic and incorporating complementary practices into their own practice, so they were some of the delivery