

WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

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CAM In Self-Care and Wellness

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Volume II
(continued)

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One of the things it is going to take is shifting our idea about the food industry and these contracts that are so popular between the soft drink companies in the schools where they compete to have Coke or Pepsi come into the school and have the vending machines.

Our love affair with capitalism means that we just make everything available, and if you have got the money, great. You can put the money in the machine and get whatever you want. We think that if the government were to interfere with that, that is a no-no.

It also goes all the way into the food industry in restaurants. That competition is based on which restaurant can serve the largest portions. Vendors at every social event; food is seen in our culture as entertainment rather than as a primary source of nourishment.

So I think it is very fundamental. It goes very deep into the core of our thinking about the role of food, and it just pervades all areas. So I am not sure I have the answers today, but I do know that the average person is carrying around a lot of guilt, food guilt. People say, well, why should I pay you a lot of money to hear you tell me what I should do. I know what I should eat; I just don't eat it.

Postponement, or denial, or, I will get around to that, but I am not sick right now. I don't have high cholesterol, or, I don't have diabetes, so I don't see any particular reason why I shouldn't be consuming pretty much whatever I want to consume. I mean, there is a real disconnect.

So I agree that we should be teaching nutrition in our schools and integrating it through a lot of different subjects that are taught, and somehow provide incentives in the food industry and in schools to totally change the way we view nutrition. I'm sorry. I just don't have the answer today. I just share your concerns.

DR. WARREN: Sometimes we notice that low-fat diet also equals high-carb diet. Isn't that right, Dean? It is sad, but true.

DR. ORNISH: Well, it is true. One of the confusing things for people when they purport that low-fat diets are harmful is that they are often low-fat diets that are very high in complex carbohydrates. Even researchers sometimes give glucose as the carbohydrate, and then people get the message that low-fat diets are harmful for the wrong reasons.

I concur with what you are saying about school lunches. I was on a commission about eight years ago to try to improve school lunch programs. We had hearings, and kids would come in and say they would go to McDonald's because the food was lower in fat than what they were serving in the lunchroom. So there is a lot of room for improvement there, too.

DR. GORDON: Yes.

DR. WILLETT: Just one thought. This may be nothing you want to touch with a ten-foot pole as a committee, but it has troubled me recently, just thinking about this, that we related to school children and a targeting of school children, even preschool children, about nutrition ads and products, that we essentially think that children are not capable of rational decision-making about voting until they are 21, not adequate to make decisions in behavior about driving until they are 18, but at three and four, we put them in a position of making decisions that will affect their lifetime chronic disease incidence, and seem to assume that they are capable of doing that, which, it does seem to put them in a setting where they are completely unprotected, completely at the mercy of huge economic forces that are targeting them.

I find that very troublesome. I know this goes really deep into how we think about society and the freedom to advertise, but it is very troublesome. Unless we deal with this, I think we are not going to solve some this problem.

DR. GORDON: I appreciate your comment, and I think it is one of those things that we want to get up close to, not keep at a distance, and try to address as best we can.

DR. HYMAN: I would just briefly add, and I would concur with what was said, to me, it really is, I believe, on the level of what is going on with the cigarette industry, and will ultimately come to that. When we have, for example, schools that profit by getting funding for computers and resources by having their soft drink machines in the schools, that is unconscionable and it should be outlawed, I believe. It should be mandated by the government that that is not an allowable practice. It directly harms our children's health and affects our ability to focus.

DR. GORDON: Go ahead, Jeff, and then I want to jump in for a minute.

DR. BLAND: Just a very quick statement. There is only one scientifically proven way to extend life span in animals. You are all aware of that. It also extends health span in every animal species that, to date, has been studied, and that is not micronutrient restriction, but calorie restriction, 20 to 30 percent, not to

produce malnutrition, but lower than adlib calories.

Recently, Dr. Richard Weindruch at University of Wisconsin School of Medicine published what I consider a landmark paper in "Science Magazine" -- this is about a year ago -- in which he showed, with Thomas Parolla [ph], his colleague, that calorie restriction in animals resulted in the expression of their genes in such a way as it was associated through their lifetime of juvenile animals, as contrasted the same species of animal when they ate adlib diets who had the expression of patterns of oxidant stress and poor repair molecules, and what we might call degenerative molecular changes.

What I am really saying is that there is a very interesting, when we talk about message in our food, there is language in our food that creates, then, a story to our genes. This is not just an esoteric, hand-waiving concept. This goes back to machines for snack foods, convenience foods, and high-fat foods in schools. This has to do with the grease-soaked bags handed out in windows of drive-throughs where people eat off their laps. This has to do with the whole patterns of behavior in our culture that are speaking to the genes every day.

What CAM does is raise the level of observation, raise the level of discussion, raise the level of inquiry in the average person about what they are doing to their genes that creates these untoward phenotypes of premature death and disability.

DR. GORDON: Thank you.

I want to say something to the Commissioners. On our schedule, we were to stop this discussion in 10 minutes. If we continue the discussion beyond that, we cut into our lunchtime discussion of definition. So we have choice, we are at a choice point here. There are seven people who also want to ask questions.

DR. ORNISH: Let's go a little longer.

DR. GORDON: A little longer? What do you say?

DR. ORNISH: Besides, we have caloric restriction, then we will live longer anyway. We will make up the time on the other end.

DR. GORDON: Okay, so we will plan to go until noon. That will give us an hour to eat. Is that all right? Instead of stopping at 11:45.

Joe Pizzorno.

DR. PIZZORNO: Jeff, I would like to take this opportunity to thank you for 25 years of being a trailblazer and an inspirational teacher. You have fundamentally changed the clinical thinking of a new generation of physicians, including myself. Your impact on health has been remarkable. Thank you.

DR. BLAND: Thank you. I appreciate it.

DR. PIZZORNO: A question of you. You haven't talked much about functional medicine and this concept that you have developed. Could you speak a bit about how this modeling of health care functional medicine can be used as a model for changing both conventional and CAM education.

DR. BLAND: Well, thank you. I will make this real quick. We don't need another term, and so one

might ask why in the world would we have come up with a different spin on the word "functional medicine," when it has been traditionally been thought of as rehabilitative medicine.

The reason for it is, after having lectured extensively over the last 25 years, I found that words become very important in getting people to listen. Over the years, having published "Complementary Medicine Magazine" when I came back from England with a meeting with Prince Charles back in the early 80s, and then talking about alternative medicine, conventional medicine, orthomolecular medicine, holistic, is it spelled with an H or a W, and so on.

Eventually, I came to recognize that these were off-putting words to some people. So I asked myself what word would no practitioner, no matter what their discipline want to be associated with, and that is dysfunctional medicine. So I said, okay, if that is true, then maybe everybody wants to be a provider of functional medicine to improve the function of their patients over the course of living.

So we chose that as a catch phrase that would not discriminate among disciplines, backgrounds, academic pedigrees. It would be an appealing point for people with shared common interests in improving health and vitality throughout the life expectancy.

I am very proud to say that we are, I think, one of the few organizations in the country that has accreditation for post grads in continuing medical education across all disciplines now. We have earned our rights for ACC accreditation for Category 1 physicians and osteopaths. We also have credit for chiropractors, naturopaths, nurses, dieticians, and so forth.

So this construct of functional medicine is built around the premise that pathology in mid life and later life generally starts as an early warning series of untoward events that may not be seen in pathophysiology easily at a standard medical exam, but if you ask different questions related to function.

It is like the difference between an exercise EKG and a resting EKG, or an oral glucose tolerance test and a fasting blood sugar. You might not pick up syndrome X with a fasting blood sugar, but you can pick up dysinsulinism, which is a functional disability that is a risk of cardiovascular disease and diabetes, that may proceed it by 20 or more years. Similarly, with cardiovascular disease, if you look at exercise EKG versus resting EKG.

So we have looked at this whole way of thinking, which is basically to try to ask questions before the onset of overt pathology. How, then, are the modifiers of function that we do everyday, the things that wash over our genes, our beliefs, our attitudes, our lifestyles, our environments, our relationships, our diet, our exercise patterns, how do they influence the symphony of our genes in orchestrated phenotype? That gives rise to a different medical paradigm, and that is where we are focusing.

We don't consider this alternative medicine. We consider this good medicine because it reduces the outcome of necessity for a very costly interventionist medicine, which is, as we all know, cost ineffective.

DR. GORDON: Thank you.

Tieraona.

DR. LOW DOG: Well, most of my questions have been answered, but I am sitting here thinking, I guess, as a mom and a mother more than a physician, and how confusing all this gets.

I am thinking of a patient coming in, and just how overwhelming, even just listening to the presentations, 40 to 60 percent grains versus 40 to 60 vegetables, a little fruit, too much fruit, high protein diet, low fat, high protein with high fat. You know what I am saying? There is just so much, and patients come in all the time really confused about that. It is a level of confusion, and it goes beyond trans-fatty acids. It just goes into this realm of absolute bewilderment.

I am fortunate enough to have grandparents and parents that are still alive, grandparents in their 90s, and having conversations with my grandmother is just funny. She gets a big kick out of, how come people have to read a book about eating. I mean, she just thinks that is this bizarre concept, to have to read about eating.

To me, the school was what my question was about, because I think it is very disturbing to me about our children's health habits. I think food, it would be nice if we wouldn't have to make it really complicated, if it could be -- I do think it is a part of entertainment. I think eating is a social event. I think eating is a sacred time for us, and I think people need to have time to eat and share in meals.

I think that it is a sign of our society when we are in fast foods and everybody is so stressed, we don't have time to prepare. It would be nice to eat organic food. I shop organic, but I am blessed enough to have the money to do it. It is very difficult when you are living on a very limited income to have the luxury of paying \$2.50 for a tomato. You want to make sure everybody eats every last little bit of that tomato.

So it seems like it is something deeper, as always. We always come down to that it is deeper than just what it is on the surface, about diets. I don't know what the answer is to it, but I know that keeping things simple, education in the schools in science seems to be part of it, and science in high schools and elementary schools, trying to teach them about healthy foods.

I am just struck again by listening to all this incredible genius. Again, if I were a consumer that was fairly uneducated, I would leave this room still bewildered about what I should eat and how I should approach my health. I just wanted to know if you could comment on that.

DR. HYMAN: I would like to take a moment, if I could, to comment on that. My grandmother used to say, "Buy fresh, eat fresh," or if it has a label, don't eat it. I think that is a pretty good principle.

I would like to offer up the wisdom of the nutritionists and physicians and practitioners at Canyon Ranch to just briefly mention these 15 principles, because they really are very balanced. They are not dogmatic, and they speak to the things you are talking about.

DR. GORDON: One thing, Mark. I am going to ask everyone to make both the questions and the responses brief, because otherwise we won't have time to eat a peaceful lunch.

DR. HYMAN: This will be real brief. It will be real brief. Honor your individuality; enjoy the sensual and social aspects of eating; consider the balance of your meals; eat gently to satisfy your appetite; focus on clean and wholesome food; begin by assessing personal needs or goals; establish a pattern of eating regularly throughout the day; be mindful of portions; eat eight to 10 servings of fruits and vegetables a day; emphasize whole grains; focus on healthy fats and oils, including omega-3 oils, avoiding trans-fats, minimizing saturated fat; balance meals with some protein-rich food; limit sugar in your diet and avoid artificial sweeteners; be sensible about salt; and drink plenty of clean water.

And that is it. It is very simple. No one would argue with any that. Those are the kinds of principles that need to be taught, I think, through public education, through the media and so on. I think they are things that most of us would agree on, and they are very key principles that would go a long way to decreasing our morbidity and our mortality.

DR. GORDON: Michio.

MR. KUSHI: I would like to know the direction of the CAMs, whether we are admitting keeping conventional medicine as it developed on its own, and we do complementary and alternative medicine and wellness in a parallel way, or, our mission is to try to interchange conventional medicine together with the cooperating way, or, if supposedly we do that, then there are bigger issues, also, we must face, such as the drug industry, this and that, all kinds of complex issues.

Eventually, we must face current civilization itself; what is civilization; what is society; what is production under consumers and the capitalistic systems, this and that. We must face big, big issues. Either CAM is the one to go in that direction, or, CAM has some limitation, some reservation or limitation for missions. That, I would like you to consider very well because this is inevitable. Inevitably, we demand a change of the entire civilization's style. So much big issues come. We must face it.

For example, even if we penetrate the medical field, suppose, by diet application and so forth, we can so much effectively together with the conventional approach, but, again, we must face many issues there. For example, the dietary approach alone, some examples here. Chris Akbar, my research assistant.

DR. GORDON: Again, I am going to ask you to make it brief, please.

MR. KUSHI: Yes, very brief.

MS. AKBAR: I think he just wants me to comment on the best-case series that you had alluded to.

MR. KUSHI: Some totally incredible cases,

MS. AKBAR: This is recovering most within less than one year, just using a dietary approach. For example, I myself am a sufferer from inflammatory breast cancer, and I recovered in two months. I basically got diarrhea, and my whole tumor went away on this diet.

We also have pancreatic cancer spread to the liver and lymph nodes, for example, that recovered in about one year, four months; a malignant melanoma metastasized to the small intestines and lymph that recovered in about a year; and a uterine cancer spread to the bones and lungs that recovered in about one year and a half; an adenocarcinoma of the lungs spread to the liver, pancreas, bones, lymph system, and retroperitoneum that recovered in an incredible 10 months just by changing diet.

I am adamant about it because I myself am one of the recovery persons. I was left for dead. I had two to three months to live about 16 years ago, and was basically left for dead by the chemotherapy and radiation. I simply changed my diet, and, like I said, in two months I got rid of my tumor. I know the effectiveness of it. I am from a scientific background, and I just decided I had to do some research in this area and try to promote it as much as possible.

I have seen the same thing with inflammatory arthritis, and inflammatory bone and bowel disorders, such as lupus and rheumatoid arthritis. I have seen people recover in just a short time from things like this, that are sort of medically impossible to work on, ulcerative colitis, for example, and cystitis and ankylosing spondylitis can be recovered very quickly.

So I really, really think it is important to save the tax dollars, to save people the misery that I went through. I really want to change this system, and if it is upside down, then it is important.

DR. GORDON: Thank you. We have to move on.

The next question is Wayne. I think is, we are very interested in the information, and we will include it, especially as we think about research issues.

DR. JONAS: Oh, so I don't have to ask my question, because I was going to ask about research.

As usual, my wife summarized everything in 15 seconds this morning. She loves Coke, and the reason she loves Coke is because she is from a very poor family and every Sunday her father would take her out and buy her a Coke, and it was their special time together. She absolutely loves Coke.

It was a psychological cause. However, she is now addicted to it; she just likes it. However, she found a religious cure. For Lent, she gave up Coke, and she has lost five pounds. So she has addressed a major health care and nutritional problem in this area.

So, how do we study that? I am being a little tongue-in-cheek here, but I guess one of my questions is, specifically Dr. Willett, is the mainstream, conventional medicine ready for holistic nutrition research prime time?

I don't mean that just in a conceptual way. I mean, are we really ready for it; do we know enough about what to study in a randomized control trial. For example, to say okay, we don't need to study folic acid because look what happened when we studied beta carotene, or something else like that.

Do we have the understanding, the knowledge base, the methodologies, and the conceptual things that we need in order to kind of jump to this next level?

DR. WILLETT: Well, there is no simple answer to that, obviously. You might like to study, if you really could, everything in a randomized trial, but the reality is you can't. A couple of trials done to try to study smoking cessation in prevention failed to produce any effect.

So that, you have to remember that almost the bigger, the more complex the question, the more difficult to study biorandomization. It is very good for pills, but not for whole changes in behavior, and particularly where some of the disease outcomes may not be manifested for several decades later.

So I think we need to put together the best possible data that we can, and we need to keep trying to improve that quality of data. We have come, I think, a long way in the last decade or so, but more can be done. We can get a lot of clues from genetic polymorphisms. This was mentioned earlier, the MTHFR variants, if they are associated with disease outcome. You also have an association with folic acid in outcome. I think both of those are reproducible observations. You probably don't need to do a randomized trial. The evidence can become compelling.

So there is a whole gradient. I think it is possible, as we have done with smoking, with physical activity, with all occupation exposures, to come to important interventions without randomization.

DR. JONAS: But that requires we agree that this type of data is going to be enough to make it a public health or other types of decision.

DR. WILLETT: We have been doing that for a long time. Again, almost all the preventive steps that we have achieved have been done without randomized trials, prevention against sunlight for skin cancer. You could just go down the list, in addition to all of those that I have mentioned.

I do worry, though, that, just in the last 10 or 15 years, this so-called evidence-based medicine, in some people's interpretation, has exclusively focused on randomized trials, which I think could be a mistake because it definitely puts pharmacology in a much greater advantageous position, because it is much easier to do randomized with drug and placebo.

So I think it is a careful weighing of all kinds of evidence. That should not be interpreted as being lax about giving good quality evidence. We need to get the very best we can, but we can have, for all those things I have mentioned, very compelling evidence without needing to have randomized trials.

DR. JONAS: Having the evidence pyramid itself kind of feeds into that situation, doesn't it?

DR. WILLETT: I think that can be helpful. Where it is inclusive, all kinds of evidence is allowed and you strive for the best. I think nutrition has been an area where the evidence base, as I mentioned earlier, has been very weak. That leads into these kinds of very conflicting messages, where the only way to sort them out is by having better quality data.

There is no shortage of hypotheses, to go back to your original point about different aspects of diet and weight control. There is at least a dozen competing hypotheses, and it is not too hard to sort those out by actually randomized trials. Other things are more difficult to study, but that one, we could get a grasp on it and solve a lot of that, just within a few years if we put our attention to it.

DR. BLAND: Wayne, just real quickly, I think this methodology that I was describing briefly, which is just emerging, which is the genomic, or even proteomic research, is going to allow us to ask questions and get answers that we previously have not been able to.

For instance, only through pattern recognition using informatics, can you start to understand complex gene sets that are being expressed in different ways. In single genes, you don't get the answer, but in multigenes, you can start getting the answer.

Now, why am I raising that? Because you can imagine experiments, and in fact these experiments will be done, in which you put a person into body-mind therapy or acupuncture, or you put them into visualization therapy or exercise therapy, and you look at the effect of various envelopes of synchronous genes that express themselves in populations that have differing kinds of clinical signs and symptoms. You characterize them and you have particular exclusion criteria.

This allows an entre into looking at the genomic message as translated into phenotype in ways that we have not previously had availability. By the way, these gene chips that we are using cost only about a cent and a half per gene, 6,347 genes on a one-square centimeter chip.

So what I am saying is that we are really witnessing the emergence, through genomics, of some potential ways of exploring these relationships at the physicochemical level. Now, that may not answer all your questions, but it does get to some of the things that are more hard than soft that might help us to answer these questions.

DR. JONAS: I hope it works out as optimistically as you paint it. I am a little concerned that it may be, in fact, adding so much more data that it becomes even more confusing, and perhaps we have the tools to do that, but thank you very much.

DR. GORDON: We have four more people, and we have four more minutes before 12:00. So I want to get a consensus. Should we stop at 12:00? Because we have to begin again at 1:00.

DR. BRESLER: Pass.

DR. GORDON: David, you pass? Okay.

George Bernier.

DR. BERNIER: This is also for Dr. Bland. In this brave new world of genomics that you have talked about, by all criteria, it ought to be a wonderful way of identifying people who have aberrant genes and identifying them, and putting them on a program that can fix it.

Are you optimistic that, since there is such a large number of people who are alive who are not in a mode to treat or avert their problems, that the next generation is going to be much more open for that?

DR. BLAND: I think your point is a very good point. That is the whole structure of the scientific revolution, a Kuhnsian concept: how do we get these major paradigm shifts to occur; is it by accretion of the slow evolution of knowledge, or is it step functions like the panda's thumb, where suddenly everyone wakes up tomorrow morning saying, well, this is so obvious, the way that medicine should be traveling from here on.

I believe we are at the threshold of a paradigm shift equivalent to what happened at the Pasteurian vector-disease period at the turn of the last century, and I think it will create a changing Id about how we see medicine, because what we have learned from the Human Genome Project is not what people expected. They expected to find out how we would die, but what they are finding out is how we will live. That is a very remarkable different spin on the data set.

In fact, literally thousands of different single-point gene mutations that people have found that are associated with specific diseases constitute less than 5 percent of the cause of disease. Ninety-five percent of the cause of disease are multigenes that are related to how we plunge our genes into a harmful environment that is unique to ourselves, which are modifiable. That is CAM, modifiable.

DR. JONAS: Thank you.

DR. GORDON: Thank you.

Joe Fins.

DR. FINS: Another question for you, Jeff. Your comment about polymorphisms and the genomics, is it

possible to conceive of a world where the gold standard really becomes trials of one, when we really understand the biochemistry of individuals?

Louis Thomas talked about halfway technologies. We almost have a halfway methodology with the randomized clinical trial right now, in a sense, because we are studying such complexity that we get into a kind of pharmacological reductionism. We can only study drug trials, and bigger questions are more difficult.

What do we do between now and then with uncertain information, with medical uncertainty? When does an idea become a therapeutic? How do we get to this new era of genomics?

DR. GORDON: All this in one minute, Joe?

DR. BLAND: Well, I will give a 15-second answer, and then let Dr. Willett give the other 45.

My quick 15-second answer is that, I think we are going to cut the cohorts in these analyses narrower and narrower. We will start with quintals, and now we are going to get septiles and octiles and deciles. We are going to get more and more cohort analysis. It will give us more differentiation for personalized medicine.

Now I will turn it over to Dr. Willett.

DR. WILLETT: Thanks. We are obviously going to try to do that, but in the end I think it is an open question how much we will learn by doing that. No. 2, we don't have to wait. We already know we can prevent 90 percent of diabetes, more than 80 percent of coronary heart disease.

I think we will learn something, to be sure, but we don't have to wait until then before we can make enormous inroads on improving our health.

DR. GORDON: Charlotte.

SISTER KERR: I think this is a political issue. I have about 10 seconds, and so I want to say, I cannot tell you how emotional I feel about the subject. We have an obesity epidemic. We have a violence epidemic. If we had a Legionnaires epidemic in our schools, we would be on every national network tonight.

What do we need to do to make this politically relevant? We have content. What you all are doing is phenomenal. It is all the things we have been saying, but we have got a drug abuse problem going on, in my opinion. Do we need to put it under drug abuse and get some attention?

So we will have no more time for you to give me genius, but if you would like to leave it in writing. We know what is going on here. We have no ethics. How can we grow little brains on sugar water and expect them not to be violent and all the rest? We have been talking long enough, folks. We are here to try and do something. I don't want to be a participant of more of the same. Health education hasn't changed behavior much since I went to graduate school in '72.

So I thank you very much, and I would appreciate any input.

[Applause.]

DR. GORDON: Ming?

DR. TIAN: A quick question. I think the USDA, Department of Agriculture, has got several very big institutes. One is located in Beltsville, and they are supposed to do a very good job for nutrition. They are studying typical, conventional nutrition studies.

Do you have any suggestion regarding an increased budget? Therefore, those institutions can offer different grants for CAM nutrition projects.

MS. REESER: It is my understanding that the USDA did announce, recently, that in the coming year they would be making significant funds available to research obesity through all of their nutrition research centers.

So that is an upcoming agenda. It should be very interesting to see what studies come out of that. Whether CAM would be integrated in that, I don't know.

MR. DeVRIES: There is some question whether, under the new Administration, that is going to continue or not.

DR. GORDON: Go ahead, Walter.

DR. WILLETT: Just to say, I think to, essentially, hold our feet to the fire to make sure that it really happens is an important thing, and that should be just a beginning. Again, it doesn't really matter whether it is funded through USDA or through NIH, as long as it is done. There has been some commitment. We should make sure that they follow through on that.

DR. GORDON: Thank you all for feeding the fire of our passion, and for bringing us a lot of light as well. We really appreciate -- obviously, all of us appreciate the panel very much.

[Applause.]

DR. GORDON: We will be back here promptly at 1:00. Thank you very much.

[Lunch recess taken at 12:05 p.m.]

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AFTERNOON SESSION

[1:10 p.m.]

Integrative Approaches to Wellness: Self-Care

DR. BRISBANE: I am here to address the Commission about underserved and minority communities, and the integrative approaches to wellness: self-care.

Most underserved minority populations and people of color, particularly those of African ancestry are champion of self-care. They are also among the most secretive about the things they do and take when it

does not conform to the majority community or conventional health care standards of practice.

They tend to be relatively open about their use of conventional therapies and chemical medicine prescribed by a physician. Hence, observers are often led to believe conventional therapies and chemical medicine constitute their sole approach to gaining and maintaining wellness. That, parenthetically, is why people of color, of whom a great number are considered the underserved, are not included in any significant number in CAM surveys regarding their use patterns.

Just as the U.S. Census Bureau is trying to find better avenues to get people of color to support their own best interests by participating in the census count, I recommend that, despite people of color feeling the need to be secretive about their CAM use, that this commission have its report to reflect that CAM does not become POCAM, meaning People of Color Alleviated Medicine.

While the majority of underserved populations and people of African ancestry use integrative approaches to wellness, they do not access either one of these health systems initially. At the first sign of a developing health problem, they are mentally exploring what is available in the home to stop progression of the illness.

Neither a conventional doctor, nor CAM, or ancestral health care practitioner, is the first source to whom they turn. The medicine cabinet, the kitchen cabinet, the refrigerator, and other places in the home are likely to indicate the family's initial self-care practices.

Stored in these places is chemical medicine, including several years' old, unfinished prescription drugs, over-the-counter drugs, vitamins and herbs purchased after seeing them advertised on television, and food medicine such as cayenne pepper, garlic, prunes, and vinegar.

Most underserved populations, and specifically African ancestral people, are quite clear when they should or should not use complementary and alternative and ancestral medicine, and the appropriate time to use these chemical medicines and conventional physicians. They are less certain, unfortunately, when and if it is advisable to share with their conventional physician their self-administered health care or the role of homeopath or herbalist or faith healer plays in their wellness program.

To address this problem of "allopathic-doctor-sharing phobia," there should be a policy that requires both CAM and ancestral practitioners, as well as conventional health clinicians to ask every patient about her or his use of conventional medicine in therapies and natural medicines, and the so-called alternative therapies they are using.

This, however, must be done in totally sensitive ways or it will not achieve intended results. Each cultural group will define what it considers culturally sensitive if they are only respected enough to be asked. It should be mandated that their answers are recorded.

Additionally, it should be required that both conventional physicians and CAM practitioners read to every patient a statement which advises the patient of the fact that her or his health, ability to be cured, and life could depend on the patient's revelation of accurate information.

Some underserved minority populations will not know that the vitamins and herbs they are taking are things which they should report to conventional health care practitioners. They are likely to believe anything they can purchase without a prescription as easily as they buy bread, milk, eggs, and fruit, are not reportable items. Therefore, it is important to realize that not reporting natural products to

conventional health practitioners is not necessarily an attempt to conceal this information.

Because they use them in their self-care wellness program, they do not readily think of natural products when they talk to conventional health care providers. They equate these conventional providers with someone who is basically interested in what chemical medicine they are taking for illnesses and diseases.

Many people of color believe in the power of things to ward off illness and to maintain good health. In many ways, part of their self-care and wellness program is their practice of wearing roots on their body, wearing a deceased mother's ring, a copper bracelet, and the like.

Some also carry stones and gems in their pocket or pocketbook, and will not venture away from home without these items. To them, it is not superstitious. Instead, it is to keep evil spirits away and arthritis pains away, "to cure cancer" and other illnesses. This is their mind/body/spirit connection, supported by their belief system. According to Stuart Grayson, "Although medical science has made great advances in the last decade, much medicine works because of the beliefs people have about it."

At times, everyone provides medical care to her- or himself. Many people today are accessing health care information from the Internet. Besides much of it not being accurate, some of it has not been tested, and there is no certainty that it is good CAM or conventional health information, but easily accessed health information without cost, or a modest cost, that can be self-administered, is appealing to many underserved and minority populations. They usually pay no attention to the words: "Consult your physician," et cetera, et cetera.

Several years later, when or if some underserved population and people of color of modest means read the findings of conventional doctors and researchers that a product they are taking is dangerous to one's kidney or liver, they tend not to pay much attention, if any attention, to the warning.

Based on the amount of time they have used a particular product, say, two, four, or 10 years, and it did not damage their liver or kidney, or they do not know if it has, they continue to use it. They believe in their own "research of individual satisfaction."

It is this research finding to which the underserved minorities and most African ancestral people, especially those with limited financial means, accept as valid, because, again, according to Grayson, "They believe what they experience, but they often experience what they believe."

I believe there should be more sensitivity to the public in general by having a medium to communicate to people when a product or a therapy actually needs the advice of a physician or a licensed health care practitioner. Certainly, many of the natural products that carry the need-to-consult-a-physician label should be examined, and the directive kept if it is warranted.

By the same token, it should be removed if not necessary. In many instances, if not most, people are being directed to a physician who is not likely to know anything about a natural product or its potential danger if taken alone or with other medicines. A CAM or ancestral health practitioner may be much better qualified to assist the person.

As Diane Goldner, the author of "Infinite Grace: Where the World of Science and Spiritual Healing Meet," reported from medical research that a relationship exists between religion, spirituality, and science. In some underserved minority populations, and particularly people of African ancestry, their No. 1 self-care is prayer and church attendance. In fact, they consider prayer their No. 1 herb, and church

attendance and involvement in religious rituals as their most effective self-care or mental health therapy.

An example of adherence to food medicine, many ancestral people continue, over centuries, to cook dark green leaves, collards, mustards, turnip greens, and add dandelion leaves in the pot. They eat the greens and drink the water in which they are cooked. This water is called pot liquor, and they believe it cures and prevents many ailments, including liver problems.

Does it work because of the relationship they have or had with their ancestors? Lee Galan, M.D. answers: "Research on the placebo effect leads to the inescapable conclusion that placebo is not a pill or a procedure, it is a relationship."

Then I will skip down to my last point, which is, finally, I recommend a study or studies by and of various people of color groups, specifically African Americans, Latinos, Native Hawaiians, Native Alaskans, Native Americans, and others, to determine their use of CAM and what ancestral practices that are used in their self-care programs. Only then will they know if they are healing themselves, or hindering a better health outcome based on the infusion of current scientific wisdom.

In some situations, they may find that what is old or all of what our ancestors taught us may not constitute a truism today. Our ancestors had no way of knowing nor imagining the possibility that we would inherit a world as we know it today.

These groups, I am certain, will find intellectual ancestral properties that should be protected because they are equally as valuable today as they were centuries ago. The government should publicize the results in their communication with different underserved minorities and people of color; a new way of operationalizing: "I am from the government and I am here to help you."

DR. GORDON: Thank you, Frances.

Cathy Moxley.

MS. MOXLEY: Good afternoon. I am here to address the area of corporate wellness, what corporate America is doing or can be doing in the area of wellness, specifically relating to CAM.

Today, over 80 percent of America's businesses with 50 or more employees have some form of health promotion program. As members of this commission are well aware, more than 50 percent of deaths in the United States are caused by lifestyle-related problems, including smoking, sedentary lifestyle, poor nutrition, and obesity.

Because of the large percentage of time most Americans spend at the workplace, what better place to target health promotion efforts and information dissemination. In addition to the benefits to the individual, corporate American also has much to gain from investing in employee health.

These benefits primarily fall into three categories. The first, obviously, being health care cost economics, involving injury avoidance; health consumerism; and chronic disease management. The area of productivity also includes benefits from reduced absenteeism; reduced injury and disability; decreased turnover; and increased moral.

Corporate image is also an area of benefit for corporations, both as a positive reflection of their corporate and community citizen and loyalty factor, as well as a recruitment tool, giving employers a competitive

advantage.

Marriott International's Wellness Program began in 1993. In addition to the reason listed above, Marriott also has a link to corporate wellness, due to the longstanding philosophy of the taking care of the associate, and the associate will take care of the customer. In addition, as part of Marriott's human resources strategy, they have included many efforts to increase their visibility as a preferred employer.

Marriott's wellness efforts fall into four different departments, the first being the "Wellness & You" Program, which is a comprehensive wellness program that I will highlight with many of the things I will list in a moment.

Three other departments round out Marriott's wellness efforts: a full-service, on-site fitness facility, including group exercise classes, fitness testing, personal training, sports leagues, and the like; an employee assistance program, which is also common in many corporations, with a licensed clinical social worker for mental health and other counseling issues; and an Associate Health Services Program, which is on-site nurses for injury and illness management.

The type of initiatives that Marriott has done are similar to, again, other companies, and I will list them. Things like health risk appraisals are a cornerstone of most corporate wellness programs. Health risk appraisals give corporations the tools they need to do screening and assessment of how an employee stands in a number of health areas. They can then find out what the major health needs of the population, and also identify those that are good candidates for follow-up counseling.

Other health screenings might include things like blood pressure or cholesterol, bone density screening, and skin cancer screening. Marriott's efforts include a monthly newsletter that has a monthly topic for our programs to address that area. Lunchtime seminars, multiple-session programs or one-time awareness events could fall into those categories.

Programs would fall into the areas of smoking cessation, nutrition counseling, weight management programs, stress management programs, back care, lactation programs, health fairs, a resource center, incentive programs, ergonomics, flu shots, self-care, and travel health information, as well as committees and advisory councils.

Marriott's past and present wellness programs that are specifically related to CAM include our seated massage program, yoga classes, tai chi classes, lunchtime seminars on various CAM topics, as well as exhibits at our annual health fair on various CAM topics such as chiropractic practices, information on acupuncture, biofeedback, magnet therapy, and nutritional products.

In addition, various newsletter articles have addressed CAM topics throughout the years. Our most CAM vendors, and I use that term because vendors commonly target corporations for their products and their services, are chiropractors and nutritional products. In fact, a week probably doesn't go by that I don't get something else in the mail from another product or another company who would like to come and speak to Marriott employees or offer their products to Marriott employees.

What I see as emerging or continually prominent issues in corporate wellness for the future include the areas of obesity, diabetes, mental health, and heart disease. Obviously, it is reflecting the similar emerging health trends of the nation, but again, in the corporate environment we see this increasing at an alarming rate.

The escalation of health care costs, especially pharmaceuticals, needs to be addressed by corporations. The inclusion of health promotion into the medical and because mainstream, such as making health promotion procedures reimbursable, would be important. As well, increasing allocations for health promotion research to better reflect the huge burden of lifestyle on disease and death in the United States.

Obstacles in corporate wellness currently fall into several major categories. The first being, that while there is much research supporting the financial impact of health promotion, in difficult economic times, wellness programs are among the first to be cut in corporate American when difficult budget decisions must be made. Senior management support is crucial, and corporate politics often plays a factor in the growth or decline of a wellness program.

The last, is that many of the benefits of corporate wellness programs are long-term, while an individual's employment with a particular company might be short-term. For instance, the way that many people joke about it, is that if you are implementing programs to prevent heart disease, you are just saving a heart attack that is going to happen when the employee works for somebody else 20 years from now.

As far as opportunities that are specific to CAM, let me first address the obstacles because that reflects the opportunities. The general public's interest and hunger for information regarding CAM topics obviously extends to our subpopulation in the corporate world.

A multitude of programs, vendors, and providers target corporations, and they extend along a large continuum of credibility. The corporate wellness professional may sometimes have difficulty making decisions regarding the credibility of a CAM topic or a CAM particular provider, given the constantly changing status of research.

Because providing information on programs through the workplace can be construed as the company endorsing a concept, whether explicitly or implicitly, this responsibility makes delicate work of navigating the credibility and appropriateness of what can or should be offered at the workplace.

Ultimately, we strive to strike a balance between offering well-developed programs on more well accepted modalities and concepts, and also offer periodic exposure on a more awareness-based level on less proven topics and modalities.

Another obstacle for corporate wellness implementing increased CAM programs is finding the right providers, again, being sure of which providers are credible, which ones are going to fit into the corporate environment in a better way and are going to fit the logistical needs that we have.

The opportunities, therefore, specifically to CAM and corporate wellness, are increasing the methods for standardizing, regulating, or credentialing providers so that we can have increased confidence in program and vendor selection.

And that is all.

DR. GORDON: Thank you.

Karen Prestwood.

DR. PRESTWOOD: Good afternoon. Being a geriatrician, I am starting with a case about an 85-year old

man who had been healthy his entire life. He was a great outdoorsman who loved fishing and gardening and walking in the woods. He had always been active in his local church, and he is surrounded by a loving wife, two children, and many grand- and great grandchildren.

One day on his usual walk, he developed angina in the hills of his neighborhood, and on further evaluation it was determined that he had significant coronary artery disease, and he underwent bypass surgery. He fully recovered from that surgery and went back to his usual activities, albeit on several new medications.

Several years later, he developed a case of shingles, or herpes zoster, for which he was treated. However, he developed chronic herpetic neuralgia and was disabled by the pain. Over the next six years, he declined to the point where he was only able to get out of bed for several hours per day. He gave up gardening, and it was even painful for him to be embraced by his family.

In spite of the pain, he continued to walk daily, until one day one of his pain medications made him so clumsy, that he fell and broke his nose. After that incident, he was afraid to walk. He tried other medications, and even nerve block for the pain, but none of these interventions helped his pain, and all caused side effects.

His physicians told him that they had no other options for him, that he would have to live with the pain. This man is my grandfather, and as I began to explore the possibility of CAM with him, I found that not only was it difficult to find practitioners who were accessible to him, because he no longer drives, but he was unable to afford the fee for a treatment course. Further, he required some convincing to even consider CAM.

Now, I am sure you have heard stories like this many times today, and at other times during your work. My grandfather's story helps illustrate some of the points I would like to make related to the use of CAM to promote wellness and self-care in older adults.

By the Year 2020, about 20 percent of the world's population, and about 8 percent of the U.S. population will be over 65. It is estimated that roughly that there will be approximately 65 million older adults in the Year 2020 in this country.

With aging, there is a wide variety in the apparent rate of aging among different persons. This individual variation in physiologic efficiency increases with advancing age. Thus, the older population is quite heterogeneous, with a large proportion of older adults that have aged successfully and who continue to have few or no chronic conditions, while others may have multiple diseases and excess disability.

In a population study, about 14 percent of men and 24 percent of women between the ages of 65 and 74 reported some disability, and that increased to 23 percent of men and 41 percent of women over the age of 75.

In older adults, functional status is the most important marker for wellness. When we see patients for an initial evaluation or in follow-up, we use standardized measures to determine physical, emotional, and cognitive function. These functional measures help us to really understand how the patients are doing, even if they do not have any increases in disease-specific symptoms.

Frequently, these measures are the first indication that a particular disease process or the burden of multiple diseases is worsening. Likewise, improved functional status is an early indicator that the

patient's overall health is improving.

In older adults, wellness is related to maintaining or improving function, rather than simply the prevention of specific diseases. We do know that even those adults with high levels of disability can and do experience long-term improvements in functional status when some targeted intervention is provided. This implies that we need to provide access to CAM to older adults across a spectrum of function and across a number of living situations, i.e. the community or assisted living facilities, or nursing homes.

Encouraging self-care and wellness in older adults involves two important tasks, education of those who already believe that they can participate in their own care and who want to be involved, and empowerment of those who are skeptical about self-care and want the doctor to provide a silver bullet that will make them "well."

While these issues are not unique to older adults, the current cohort of 85-year olds may require more empowerment, followed by education then baby-boomers when we reach 85 years of age. In addition, one must consider the different needs related to CAM of those who are aging in what we would consider a usual manner, compared to those who are aging "successfully." With usual aging, the goal, again, is to maintain or improve function or quality of life. With successful aging, we would also like to add disease and disability prevention. One of the major concerns in older adults is polypharmacy, or the use of multiple medications. Older adults constitute about 12 percent of the population, but actually consume approximately 25 percent of prescription medications each year. In North America, older adults take approximately four and a half medications at any one time, and most of these are a combination of prescription and over-the-counter, including nutraceuticals.

Several studies have demonstrated that the number of adverse drug events increase dramatically with the number of medications, from about 15 percent with two medications to 50 to 60 percent with five medications.

The use of CAM may well reduce the number of medications older adults take, particularly since major classes of medications used by older adults treat diseases that have been shown to benefit from one or several CAM modalities, at least in younger patients. These include cardiovascular medications, antihypertensives, analgesics, arthritis medications, and psychotherapeutic agents.

In geriatrics, we use a framework for adjustment of drug therapies, considering concomitant disease and a knowledge of drugs that are likely to be coadministered in older patients. Along with guidelines for adjustments in dosing, are drug combinations to optimize beneficial effects and avoid adverse effects. CAM could be integrated into this framework and result in improved care for older adults.

On the other hand, older adults are typically more sensitive to medications and frequently require a reduction of dosage to minimize adverse effects, and it is possible that the same is true for CAM, particularly herbal remedies and vitamins, but perhaps also for other modalities, such as energy medicine.

As we begin to integrate different systems of care, it is important to be aware that changes in the body that occur with aging predispose older adults to adverse events, and that "starting low and going slow" should be the modus operandi until studies more clearly document safety, in older adults specifically.

Reimbursement of services and access to care are challenges that particularly affect older adults. Even in an affluent state such Connecticut, many older adults live on fixed incomes and are unable or unwilling

to pay out of pocket for CAM, even if these modalities could potentially save the health system money. Further, practitioners may accept other forms of insurance, but are very reluctant to consider Medicare.

As we begin to think about long-term solutions for reimbursement for CAM, we must find solutions that include Medicare, so that a group of patients who could potentially benefit greatly from this type of care are not excluded from it.

Access to care is also an issue for older adults who are not able to drive or who rely on family members or public transportation. Centralized facilities, in which multiple care providers practice, would enhance access to care for older adults. In addition, these centralized services would increase the opportunity for various practitioners to collaborate on the care of individual patients.

In geriatrics, the multidisciplinary team is basic to our way of practicing medicine. Geriatricians already work with and value the input of health care providers who are not trained as medical doctors, such as nurses, physical and occupational therapists, nutritionists, and social workers.

Integration of CAM providers into this geriatrics care team would enhance the work of the team and provide more holistic, and perhaps, more cost effective care for older adults.

I have divided my recommendation into education, research, and clinical care. Obviously, they are tightly intertwined, but I would just like to say that it is important that we make sure that older adults are included in research, in intervention trials that are beginning and future trials that are planned. It is important that we train health care providers who take care of older adults about CAM and integrative care, and even better, to ask them whether or not they are using some form of CAM.

In closing, 30 to 45 percent of older adults already use CAM, although as similar to younger adults, most do not tell their providers. Integrative care has the potential to greatly benefit older adults, and I would encourage the Commission to broadly include older adults in their recommendations. Thank you.

DR. GORDON: Thank you.

Christina Puchalski.

DR. PUCHALSKI: Good afternoon. I am going to talk about end-of-life care. Often, my students, when I mention wellness in end-of-life care or peace in end-of-life, they always wonder how you can put those two in the same sentence, but I think it is very important that we do address wellness, particularly at the end of life. I am going to focus my comments on the role of spirituality and wellness in end-of-life care.

Currently, a lot of work is being done on improving the care of patients who are dying, but I believe most of that is focused on the physical symptomatology of dying patients. We need to increase our focus on the spirituality well being of patients as well. Spirituality is an essential aspect of end-of-life care. Just for definition purposes, I think it can be defined as that which gives a deep meaning and purpose in a person's life, and how people cope with suffering.

It can have many expressions. Religion is but one, but also art, family, and other different types of spiritual beliefs. National surveys certainly document that people value the spiritual dimension in dying and that patients also utilize their spiritual beliefs in helping them cope. Those of us that are clinicians certainly know this from our own experience.

One of my patients struggled with sickle cell anemia until she was 45, when she died from that disease. In her last six months, we were treating her fairly aggressively with a deferoxamine for an iron overload. She came into my office one day and just said, "I would like to stop that. I don't want any more blood tests. I don't want all of this aggressive care. I really feel that I am really ready to die, and I want to work on those issues."

And so, for six months, she came to my office to talk, to be heard, to be listened to. She worked very closely with her faith community. Often it was her faith community who recognized when she was in distress, and brought her into the office to see me.

In the end, when I visited her at home, her last night was very, very peaceful. Prayer was a very important part of her life, and she utilized that. The next morning, her mother called me to tell me that she had asked to lay next to her mother in bed, put her head on her mother's chest and fell asleep, and felt very much at peace when she died, as her mother saw that.

I think this is something that we want for all of our patients, to give them the opportunity to have peace at the end of life. And so, I propose three initiatives that might help patients in this respect. The first, is that spiritual care should be available in all settings in which the terminally ill are treated. Certainly, palliative care is an excellent model of care that is holistic, including spiritual care.

The second, is that health care professionals, as well as faith and other social communities, need to be trained in recognizing the importance of spiritual care, particularly at the end of life, and also how to work within the health care system.

The third initiative is that spiritual care should be reimbursed by Medicare and other third-party insurance, and that the hospice benefit should be extended beyond six months, which includes a lot of palliative care. Tied in with that are some research initiatives that I will discuss.

In terms of the first initiative, that it should be available settings in which terminally ill patients are treated, there is a lot of data, and I am just going to do a lot of injustice in summarizing this, but one is a Gallup survey that was conducted about two years ago. A random poll in which the two major needs that people expressed, should they be dying, were, one, companionship, not wanting to die alone and wanting warm, caring relationships with their physicians.

As I am mentioning these things, think about our current medical system and whether it really does foster the time needed for doctors and others to be with their patients. Then spiritual comfort, such as receiving blessings from clergy, living on through relationships, through accomplishments, having time for ritual, listening to music, et cetera; again, do our systems allow for that.

The conclusions from this survey and other surveys is that it is as important for health care providers to talk to patients about these issues as it is to provide the physical or medical technical care to patients.

There is also data that spirituality may be helpful to people as they cope with dying. For example, patients with advanced cancer who also found comfort from their spiritual beliefs, those patients were more satisfied with their lives, happier, and also had diminished pain. There is a whole research now looking into spiritual practice as an adjunct to treating pain management.

In a national survey by the American Pain Society prayer was stated as the most common non-drug method for dealing with pain, followed by the relaxation response, meditation, touch, and massage.

Patients with cancer and AIDS felt that their spiritual beliefs helped them cope with their illness and with facing their death. They felt more ready to face their death, and more at peace.

Then there is also the data on the role of the beneficial effects of meditation, specifically the relaxation response, as termed by Dr. Benson and his colleagues, as an adjunct to treatment of patients with serious disease.

I believe that spirituality offers people hope in the face of despair. Initially, that hope might be for a cure, but as the illness progresses, that hope can change into time to finish important business, forgiveness, ability to have quality good relationships, and finally to let go.

It is critical that our systems of care allow people to have the opportunity to explore these spiritual issues, and by spiritual care, I mean that all care providers should address the spiritual issues of patients and be trained to respond to those issues; that CPE-trained chaplains and other spiritual care providers should be recognized as experts and as members of the interdisciplinary health care teams that we all talk about, and that these should be present in all settings, not just hospitals, but outpatient clinics, hospitals, hospices, nursing homes, et cetera; that patients have the opportunity to express their spiritual beliefs, their hopes, their dreams, their anxieties, their fears, and that those should be respected and listened to just as much as their physical systems. So we need to think of designing care systems that give people the opportunity to do that; and that finally, there should be opportunities made for reflection, prayer, meditation, and other types of spiritual practices for patients.

Again, I will harken back to the palliative care team concept, because I think this team concept is a good model of care, not just at the end of life, but throughout care, and again, where spiritual issues are integrated.

The second initiative is training of health care professionals, and faith and other communities, to recognize the importance of spiritual care, particularly at the end of life. Currently, a program that I direct, teaching courses in medical schools on spirituality in medicine.

In 1992, there were about three courses, and Dr. Gordon spoke at one of them. Now we have over 70 medical schools teaching these courses as part of their required curriculum, and many of the residency programs as well. The response has been very positive. Doctors want to be responsive to holistic needs of patients, but doctors, nurses, and clergy want more training, and that is a clear need still.

Faith communities are available and willing to help in the care of patients, and I think we are so focused on the doctor doing this, the nurse doing that, the social worker, chaplain, that we forget about the role of faith communities. Certainly, also, working in geriatrics, I have come to recognize how important they are in improving access to the health care system, because they are often out there in the front lines working with my patients.

But they feel that they need more training, the faith communities as well. So what do these programs need to address? The role of spirituality in health and in end-of-life care; how to address patients' spiritual needs; how to recognize spiritual suffering; how an interdisciplinary approach to care can build communities of caring. That is where the nurse, doctor, chaplain, social worker, faith and family communities can all care for patients together. Again, the palliative care model team does this.

And then, for clergy and faith communities, how to recognize end-of-life symptoms. A lot of people in the faith communities want to work with dying patients but are nervous or feel unprepared dealing with

patients who are dying and want more training on that; then, how to work within the health care systems, how to empower people in those communities to work within our systems.

Finally, that spiritual care should be reimbursed by Medicare and other third-party insurance. The data as well as all the anecdotal experience from doctors and other care providers does demonstrate, I believe, that spirituality is important, particularly in chronic illness and end-of-life care.

However, our health care systems are still driven largely by reimbursement, and physicians, while wanting to do the time to do spiritual counseling or to take the time to listen and be present to patients, are often prevented from doing so due to time pressures and reimbursement restrictions. Chaplains in outpatient settings, as well, need reimbursement.

There is a program in Colorado called Sloans Lake Insurance, which does currently reimburse for chaplain visits in the outpatient setting, and I think this would be a good model for the country in general. It is very important that these aspects of care such as spirituality be supported, and by reimbursing, I think we would give them the kind of criterion, the justification that they need.

Part of this, I believe, is carrying on research initiatives, and those can be around quality of life with specific spiritual interventions, such as meditation, chaplain referral, et cetera, looking at whether physician assessment and other assessment of spirituality does make a difference, and finally, looking at training of faith groups in other communities, measuring whether access to medical system improves, patient satisfaction improves, et cetera.

So in summary, I think spirituality is very important in end-of-life care, and to reiterate, I think the important initiatives that spiritual care be available in all settings, that there be training for health care professionals in faith communities and that they be supported in recognizing the importance of care at the end of life, that spiritual care should be reimbursed by Medicare and other third-party insurance, and that the hospice benefit not have a time limit of six months or less, but that we really bring that earlier on to care, and that we take some time and trouble to look at this area.

I think these initiatives will help the terminally ill patient and their families at a time of crisis in their lives. Dying is one of the most difficult things any of us will face, not just the patients we care for, but all of us in this room. We need to create systems of care that will recognize not only the physical dimensions of care, but also the spiritual.

By recognizing this important dimension, we will transform our health care system from a cold, impersonal one, to one that is a caring community where all our patients and their families' needs can be met.

Thank you.

Panel Discussion

DR. GORDON: Thank you. Thank you all.

Questions from Commissioners? Linnea, Joe, Effie, Charlotte, and Don, and George.

MS. LARSON: I thank all of you for your marvelous comments, very cogent and filled with wisdom. I actually have questions for all of you, but I am going to focus on one in particular, and that is Dr.

Puchalski.

MS. LARSON: Puchalski. Okay, that is like my name, Linnea.

We were given testimony, I believe it was in December, from some hospice workers. One of the things they testified to was the length of time of referral into a hospice has been decreasing and decreasing radically, particularly within the last three years. So you are making a request to extend the six-month benefit period of CHMB, and yet in the face of these referrals.

First, why have the referrals come so late on, so it is called the "brink-of-death care," and what is your logic in extending the benefit?

DR. PUCHALSKI: A couple of things. I think part of it is ignorance on the part of the physicians who make the referral. While there is good training that is starting in medical schools, it's far from perfect. I think physicians are just not aware to incorporate hospice and palliative care earlier on in the care of patients.

There is still a linear model that is thought of, which is a person is diagnosed; they get treated aggressively, and then, whoops, when things don't work, we refer. I think if we can change that whole model so that the concepts of palliative care are integrated earlier on when someone is initially diagnosed with something, even though death may be far off, I think that would change when a referral, obviously, to hospice or to palliative care would occur.

I think there is a cultural response to palliative care. A lot of people when they hear of hospice or they hear of palliative care, think that their physicians are giving up on them. In addition, in that it is sort of at the end, that there is nothing more that people can do. Again, I think we need more education on a public level that this is not just something that is done at the very end of life, but that there is a lot of wholeness and fullness in hospice care. It is not just somewhere people just go and they are given up on.

There is a third part. Many patients want to continue having relationships with the physicians that have cared for them, but because of the way that physicians can reimburse, et cetera, sometimes physicians can't continue to care for their own patients when they go into hospice. I think that also needs to be looked at because many patients elect to continue to stay with their current physician, and that might interfere in some of the late referral to hospice.

MS. LARSON: I want to respond to that because I was involved with hospice for five years and am aware of that. However, the question really is, because things have changed within the last three years. So the late referral, it keeps on shortening, the time. So as we are adding all of this "education," we are still getting late referrals.

DR. PUCHALSKI: Well, I think that we have to focus more on the education. We have education in medical school. I don't think our residency program have adequate programs, and they are a lot of the people that are referring.

Also, our attending physicians. The Epic Program is becoming more popular out there, but not all physicians are addressing it. It is often the attending physicians that are the ones that are responsible.

I mean, I understand the statistic that it is going down and it is going in the wrong direction, but that is an area I think we really have to focus a lot of our resources on.

MS. LARSON: I also commend you. I think that the model, the palliative model, or the model designed years ago for hospice care, is actually a great model for us to be looking at.

DR. PUCHALSKI: There is one more comment about all of this. I think that no matter what leaders in palliative care have done, most people still want treatment and still want the hope. We need to accept that. I have learned this through my patients, that sometimes their spiritual belief is their strong will to live and to fight.

One of the problems, I think, with hospice and palliative care is that in some places you can't have active treatment and at the same time have hospice, and so patients will opt not to do that, but if we were able to integrate both, and there are some program that do that, where you can have chemotherapy and at the same time be having hospice care/palliative care team work, I think that would also encourage earlier referrals.

MS. LARSON: I agree with you. I also know that a lot of hospices put restrictions.

DR. PUCHALSKI: Right. We need to change that.

MS. LARSON: Yes. I think we need to change it, and I think the model is a perfect model.

Can I ask one more question?

What was the cost, Ms. Moxley, of you starting up those programs? And what was the impetus for Marriott to do it?

MS. MOXLEY: The impetus for Marriott to start the "Wellness & You" program in '93 was escalating health care costs at that time, was the primary impetus. Also, in 1990 to '91 was a period of economic times at Marriott that had a lot of layoffs, and there was a lot of low moral. So this was seen as a good-news program at the time, something that needed to be done to improve moral.

So at that time, they developed a committee that was led by the Corporate Benefits Department, and they assembled people from different respective areas of health promotion, the medical director, someone from the EAP program, someone from the fitness facility, a dietician, and put together a pilot program. So at that time, when they kicked it off, they set aside an accrual account, a certain amount of money that was discretionary funds to kick it off. Then after that, it needed to be approved for a live budget.

Annually, right now, it has a budget of about \$100,000 a year, just for the corporate headquarters site, a little bit more than that, which is not very much.

MS. LARSON: Have you done any kind of money-in, money-out assessment, how much benefit to productivity, et cetera?

MS. MOXLEY: One of the difficulties in measurements in that area of health promotion is that there are certainly many factors that can influence any of the numbers that you get. So the thing that we did when we kicked off the program in '93 was start off with a health risk appraisal of having a pilot group of 500 associates go through the screening and the questionnaire procedure, and retest them again two years later.

We did show a return on our investment of about two to one, a cost savings of about \$35 per associate per year for participants in the program. At that time, there are similar research studies that show improvements, mostly with estimating, because one of the issues that is sensitive in corporate America is whether or not you are going to mingle the benefits information with the medical information.

So we did not take specific health care costs of participants in our program and see, did their specific costs go down. All we did was measure the health improvements, and then looked at national level data for estimating, with certain health improvements, what kinds of reductions you can see in health care costs.

As far as other types of measurements, like reduced absenteeism and productivity, the measurements, again, can fall into a gray area that are impacted by other things besides participation in our programs.

So measurement can be difficult, and what we have really seen in corporations is that someone who is a champion of health promotion and wellness is going to put forth the budget, just from a good will effort. If you are a champion, you are a champion. If you are a detractor, you are going to poke holes in it no matter what.

So it has really become a thing that some corporations are increasing. Due to other political things that are happening, or strategic and other initiatives that are on the plate, they fall by the wayside. So it is a rise and fall through the years.

DR. GORDON: Joe.

DR. FINS: Chris, thanks for your testimony, and for all of you on the panel. And Chris, thank you for your work in making medical schools more humane and more spiritual, more infused with that notion of healing that I think all of us embrace.

I want to sort of float an idea out in response to Linnea's question about the decreased length of stay. I think the length of stay now is 17 days in hospice with a six-month benefit, and people are referred too late. It impoverishes hospices because it is a per diem rate. It was meant to be cost-shifting for the beginning of the six-month period when costs were lower, and as costs escalated, you would balance the costs.

What is your sense of the impact of the OIG, the Office of Inspector General, and their investigation of hospices on the willingness of physicians to refer? There was an article in the Wall Street Journal in the fall that attributed the decreased length of stay in hospice to the fear of those kinds of investigations.

DR. GORDON: Joe, can you say a word about the investigation.

DR. FINS: Well, the OIG, the Office of Inspector General, has looked at hospices and has gone back and said somehow they are in violation of that six-month rule, or that people were referred too early. There have been recoupments of funds on this very fragiley financed arrangement.

I am sort of giving the answer to my question, but I would like your opinion on that, and I would respectfully suggest to the Chair that perhaps we hear from the OIG to hear about how hospices are regulated, so that we can make a difference, because we talk about wellness. Bereavement is also a wellness phenomenon, and the costs of bad end-of-life care, and failure to refer or late referral to hospice has implications for back pain and work loss. The people at Marriott can't control what happens to

hospice when their employees come in and they are not well.

So maybe you can comment on those sets of issues.

DR. PUCHALSKI: I think you did answer part of your question, that, I am sure, has an effect on many physicians. I just know that in my own experience, I would have to say that probably the biggest factor in physicians referring late to hospice is simply lack of knowledge, they are just not aware that that is something that can be done early on, their own inability to let go in the case, and a lack of communication between the physician and the patient as to what is happening with their case.

Getting back to the point of spirituality, if some of these issues can be addressed much earlier on in the course of illness. My ideal interdisciplinary team would be to have some sort of palliative care person on the team early on when people are diagnosed, so that they can also work with the physician of record, and so that things aren't done at the very last minute when people are so acutely ill, but that things are brought in earlier.

In terms of that study, I do think that that certainly impacts physicians because people don't want to get legally into trouble, financially, fined, et cetera. So that certainly would impact it, I think, as well.

DR. FINS: Just a quick related question. We are talking about benefits in an upcoming meeting, and we might make a comment, perhaps on the Medicare hospice benefit.

Is your sense of carve-outs a problem? There are a lot of hospices that are privately funded, that take away what are perceived as value-added but not really essential kinds of things, like spirituality-bereavement counseling, that kind of stuff.

So if you were to recommend to us the kind of benefit it should be, how inclusive should it be, and what would be the entitlements?

DR. PUCHALSKI: You are talking about the hospice benefit, how inclusive? Oh, I would say that from the time that someone is diagnosed a potentially life-threatening illness, they should be allowed a benefit of palliative care. That is not necessarily inpatient hospice, but I think they should be allowed that benefit. It should just be integrated as a good, whole model of care.

There is another way, I think, to improve referral to hospices, and that is, again, education of faith communities, because I think they can be very powerful in presenting that option to patients in a non-threatening, i.e. it isn't the physician that is saying, look, I am going to refer you to hospice now, and then the impression, my gosh, something really bad is happening to me; that's why they are doing that.

If faith communities can be educated to then present those options to patients, and again, work with the health care system, I think we can improve the referral to hospice as well.

DR. GORDON: Thank you.

Effie.

DR. CHOW: Thank you for the interesting and touching reports. I would like to address this to Frances.

Yesterday, we had the media and Internet and marketing, and advertisement strategies and so forth in

health care. The minority population is very much a large part of consideration, and what you said is very touching because it happens with the Chinese and the others, as you have indicated.

Those home-care remedies, is this part of CAM and what do you recommend so that people can be more sensitive to, this is a therapy that people do subscribe to, and it is very real. As you said, it is not superstition.

What do you recommend to educate the people more to this? And how can we help educate the people who are using this?

DR. BRISBANE: Well, I think it is part of CAM as many people define it, but I don't see it as part of CAM, and I don't think the people that I am talking about, the major underserved populations, define it as CAM. I think that just like prayer, it preexisted before CAM or anything else.

Certainly, some of those so-called home remedies, everybody's ancestors have some of them, and they predated CAM. That is why I refer to those kind of things as ancestral health and healing practices, and CAM as a completely different thing with its modern connotation as opposed to mixing it up with ancestral practices.

I also believe that not every ancestral practice, and what I was trying to say at the end, not every ancestral practice may be appropriate for today, because our ancestors certainly could not envision the world that we have inherited.

However, I would think it would be very insensitive for a group of people not of that culture to try to do a study about that. I think people of that culture might want to look at some of the things, like pot liquor. When you drink the water from the greens, that is pot liquor. We have used that for thousands and thousands of years.

I don't know, if we would look at it with some science infused into it, we might find something else, but I think it is worth looking at some of the practices that we all follow to see if, at this point, they may not be as relevant as they were a century ago.

But clearly, I don't see that as CAM. I don't see it as alternative. I see it as ancestral practices.

DR. GORDON: Thank you.

Don.

DR. WARREN: I have got a couple of things.

Ms. Brisbane, you talk about the underserved African American ancestral type healings that they have. All cultures have these things, and it is not limited just to African American, but all cultures.

You stated in here, they are quite clear when and when not to use CAM, when to use the ancestral, or the chemical and conventional physicians. How do they know this? Are they the only population that is quite clear when to use one or the other?

DR. BRISBANE: This often happens when we start talking about people of color. Because one thing is right, doesn't make something not right. Because African Americans use it, it doesn't mean the Jews

don't use it, Polish people don't use it, and so forth.

My charge was to talk about what African Americans and people of color in underserved and minority populations use. However, if anybody else uses that, if somebody else was up here talking, they would probably include that. That was not my charge to defend what other people use. My charge was to talk about underserved minority populations.

Being black for over 60 years, and I made it very specific about African Americans, is that we, just like other people, know when an illness has progressed to a stage that we can no longer use grandmother's remedies to do it. I think everyone does that, but maybe the reasoning behind it may be different for each culture.

DR. WARREN: Well, I thought maybe I was a little weird because I have eaten greens and drunk pot liquor for years.

DR. BRISBANE: I would hope so. I would hope that more people did that.

DR. WARREN: Ms. Prestwood, we have a situation in the nursing homes right now and in hospitals, where we have long-term care patients that are brought in, and the staffs are being encouraged to counsel the patients not to bring in their herbs, or not to bring in their nutritional supplementations to the facilities, because when they run out of the product, if they are still in care, then the hospital or the nursing home has to pay for that out of house, and to cut their cost, they are telling people not to bring these in.

What are your feelings on this?

DR. PRESTWOOD: Well, that is true. I have done a lot of work in osteoporosis and we have been trying to encourage people to take calcium. Calcium is not reimbursed, so they don't want to pay for calcium as well.

I think that my simple answer is to say, have people bring their own herbs and vitamins in so that they can take them. I think this is a lot easier in the nursing home where you have families coming in every day, usually, to see them.

In the hospital, I think we need a lot more work because I think, one, hospitals are very conservative places and they don't want you taking herbs and other vitamins. Like the resident physicians about spirituality, frequently they don't have any training in any of the herbal or nutraceutical agents.

So I think that we just need to work, especially in nursing homes, to try to change that policy. Again, I think it is an issue of education, education of nurses, and education of medical residents, and education of hospital and nursing home administrators, et cetera.

DR. WARREN: The other thing that comes to mind is that most patients of alternative care do not consult with their physicians or anybody else in the health care field. Even if they are asked, they decline because of the distrust of authority, because of a disenfranchisement by authority when they say, oh, that gives you expensive pee.

DR. PRESTWOOD: Right.

DR. WARREN: So I think we need to address that, somehow, in aging, and with underprivileged groups.

DR. PRESTWOOD: I totally agree. I find that since I have begun asking my patients about whether they take herbs, et cetera, they trust me more. Maybe the first time I asked them, they didn't tell me all 10 they were taking, but now I do it as a matter of course. They come around very quickly if you appear open.

Again, I think that is where the education comes in. It is the same with spirituality. The first time I asked somebody about spirituality in an outpatient visit, they were thrilled that I actually asked them. So I think that it is a matter of beginning to regain the patient's trust.

DR. GORDON: George DeVries.

MR. DeVRIES: Dr. Puchalski, you had mentioned earlier a suggestion related to reimbursement for prayer-associated services by health plans.

We have talked a lot about prayer in this particular White House Commission hearing, and yet you look at, shall we say, the way prayer is utilized, on the one hand, those who have a strong belief in the power of prayer would seek their friends, their pastor, their rabbi, their priest, in their community.

I have a hard time conceiving how those would even want reimbursement in a health plan system. I can conceive how more on a hospital or a hospice side, where if you have chaplains, how they would seek reimbursement.

I guess I am just curious, from your experience, how would you see this working in a system of reimbursement?

DR. PUCHALSKI: First of all, I didn't talk about prayer being reimbursed. I think that is a very personal practice of patients and individuals, and that also gets into the whole area of inflicting certain beliefs onto patients, which I think is unethical.

I am talking specifically about spiritual care. Someone once distinguished clergy from chaplains by saying that clergy generally provide religious care, and that is a different thing than I am talking about. Chaplains tend to provide spiritual care. CPE-trained chaplains work with patients regardless of their specific religious beliefs, or whether they are the same religious belief or not. A lot of the type of training of chaplains has to do more with counseling, listening to patients, trying to help them resolve spiritual issues.

An example. A patient of mine who was diagnosed with HIV and thought that this was a punishment from God, and would not proceed with any medication or treatment, and just gave up and was going to die because she had been waiting for the punishment for 15 years.

I worked with her, but so did the chaplain, who is trained in much greater depth than I think medical professionals are, in helping that patient work through some of those issues, distinguish between what is low self-esteem and guilt versus what comes from her specific belief system, and then try to help her.

In this case, she was able to forgive herself and then move on in therapy. I am talking about that kind of care, and that is the kind of care that is in palliative care settings as well where there is a chaplain. It is not specifically related to prayer.

I was on a panel where we discussed the reimbursement, and it does raise a lot of ethical issues. There are clergy that will not reimburse for spiritual care because that is unethical. On the other hand, I think chaplain services, where they are trained and they are dealing specifically with spiritual counseling, I think that can be reimbursed for.

The same with physicians, I think obtaining a spiritual assessment is just part of good medical practice. We don't have to put down on our billing sheets an ICD-9 code for a spiritual history. We don't do that for a sexual history or anything else.

However, to take the time to counsel patients and to talk to them about that, there should be some mechanism for physicians to bill for that kind of time, which may be under general counseling. Those kinds of models I proposed.

DR. GORDON: Thank you.

Dean.

MR. DeVRIES: Thanks for the clarification.

DR. ORNISH: This is a question for Dr. Brisbane.

You have communicated very eloquently about the cultural obstacles for African Americans to seek out not only conventional but also complementary approaches. You also have a lot of experience. You are dean of the Black Alcoholism and Addictions Institute with substance abuse of alcohol and other drugs like that.

Although, this is not unique to the African American community, certainly in my own practice I have found a resistance to seeking treatment from conventional, or even alternative approaches, in many African American patients that I have, for that matter, other patients too, to alcohol- and drug-related problems.

I am wondering, in the same context of describing obstacles to seeking conventional allopathic or complementary approaches, what have you found to be particularly culturally sensitive in the African American community when dealing with these issues?

DR. BRISBANE: See, I think because we work on a time scale in terms of reimbursement, and there is no reimbursement for caring, because of that, we show less of it. I believe, and I have seen, people who are not African American who have a wonderful working relationship with African Americans and Latinos and so forth, because if we spend time in showing that we care, because African Americans care more about how much you care than they care about how much you know.

If we spend time demonstrating that we do care, and demonstrating our ability to want to have a relationship, you can work as effectively with someone who is African American as I can, but time must be invested in the relationship, because among African Americans and people of African ancestry, in terms of our world view, our highest value and respect is for the interpersonal relationship.

So if time can be invested in that, then we go down the line with having faith in you. You become part of the medicine because we really like you. With African Americans and most people of African ancestry,

there is no such thing, as our parents taught us, as "you don't have to like me, you just have to respect me." With us, it is one in the same. If I don't like you, I don't respect you.

So we have to spend some time with, not making people our friends, but being very friendly, which, from that comes the relationship on which we can build a relationship with the person to help them, because as all of us know, if we perceive that the relationship is toxic, it will make us sick. So we do everything to get out of those types of relationships.

DR. GORDON: Thank you.

Charlotte, and then Linnea.

SISTER KERR: Mine follows up on that, Doctor. I was going to say that the most profound thing I read in your report, all of which was incredibly helpful, was the concept of the interpersonal relationship. I mean, the impact of that. A spin-off on that that came to mind, to me, was the HMO model, which I believe feels that practitioners are interchangeable. I don't believe that, but if you do, you are in trouble with that population.

But I wanted to ask you, do you think that value comes from the wisdom of your ancestral practices? Does it come from a negative experience of being hurt in certain social contexts? Does it come from some innate knowing, on an energetic level, of love or spiritual knowing?

DR. BRISBANE: I think it comes from all of that. From time to time, one thing is dominant over the other, but I think it comes from all of that. And then, I think a lot of it comes from just mystery. We will never know.

DR. GORDON: Linnea.

MS. LARSON: Dr. Puchalski, having trained, in behavioral science, family practice residents, and actually having witnessed their terror at making referrals into hospice and their completely falling apart, would you consider, in your curricular changes, putting a wellness component in there for the care of the physician, that it is essential for their wellness, to consider how they react to death and dying first, before they even understand how to give a referral?

DR. PUCHALSKI: That is an integral part of our course. It is called "Spirituality: The Caregiver." People call it different things at different schools, but basically it is having residents and medical students address their own belief systems, whatever they may be, what kind of self-care do they use for themselves, addressing their own mortality, that before you even can approach your patient who is ill and dying, what about your own needs.

I just want to piggyback a little bit on what Dr. Brisbane said. It is not just for the African American community, but I think everybody wants caring relationships with their doctors. When we design our systems of care, currently that just doesn't allow it. We don't allow the time that people have to form those relationships.

As you were just saying about the HMO, people go from one practice to the other. When I teach my residents, and particularly in those sections on the spirituality of the caregiver, one of the things that they always raise is, "I am becoming a physician because I want to care for my patient; I really want to form those relationships, but now the system is not allowing me to do that."

People, practicing docs, residents, are losing their own sense of meaning in their professions because the system doesn't allow it. So we need changes on that level.

DR. GORDON: Thank you. Thank you all very much. I wanted to make a final request and a final response to your comment. I think that I would agree very strongly that we need to nurture the internal environment and the milieu of the people who are providing help, and I think we as a commission feel the system needs to change.

In addition to all that you have given us today, we really would like, both, model programs that you know of that illustrate the points that you have been making and any specific recommendations.

I know Joe and Linnea were asking you, Christina, about recommendations for, how should it be; how should hospice be funded; what should it look like; what kinds of services should there be for older people who are institutionalized; what kind of workplace services should be mandated; what should be available for people of color in their communities.

So the more specific you can be, and the more backup information you can give us, you will help us even more than you have already helped us today. Thank you very much.

[Applause.]

DR. GORDON: We are going to take a 15-minute break, and then we are going to have public testimony.

[Recess.]

Public Testimony

MS. CHANG: Would the following speakers please come up and be seated: Michael Zeng, David Molony, Marcellus Walker, Diana Chambers, Robert Miller, Kathleen Quain, Donald Epstein, please.

Commissioners, you have been given almost everybody's oral statement. I do want to bring your attention to one oral statement that you received from an individual who we unfortunately don't have time for today, Janet Ziegler, and she is at the end of your packets. Look for her statement as well to review. Thank you.

DR. GORDON: Good afternoon. Thank you all for being here. We will go down the list, and as Michele said, at the end, we will have time for questions from the Commissioners.

We will begin with Michael Zeng.

DR. ZENG: Please allow me to introduce myself a little. My name is Michael Zeng, a doctor of Oriental Medicine, M.D., China, president of the International Institute of Chinese Medicine in Sante Fe, New Mexico, vice chair of Oriental Medicine Chinese Specialists Advisor Board under the AAOM.

Thanks for the Commission giving me this opportunity to address some concerns of alternative medicine policy. Today, my speech is regarding Oriental Medicine. Oriental Medicine is based upon tradition Chinese Medicine, which includes acupuncture, Chinese herbology, bodywork, diet, psychological

counseling, tai chi and qigong, physical and mental exercise.

It is an approach to health care with over 4,000 years of history, and has developed its systematic theory and clinical skills. These are documented in a vast body of literature covering its theory and practice.

An important feature of Oriental Medicine is its recognition of the interconnection between the physical, psychological, and the spiritual aspects of the patient. It stresses the integration of all these in order to treat the whole person rather than the disease, with a focus upon prevention as opposed to cure.

Today, Americans are turning to Oriental Medicine in ever-increasing numbers. They view it as providing simple, economical, and effective treatment with no major side effects. Surely, both Western and Oriental Medicine approaches have an important role to play. It is vital, therefore, for the optimal delivery of services that reimbursement for acupuncture and Oriental Medicine treatments be addressed by both private and government insurance programs. We look to the Commission for assistance in achieving this important goal.

Like many of my colleagues, I am very concerned that many states now allow the medical doctor to practice acupuncture with a bare minimum of related training, or even with no training at all. This removes acupuncture from its intellectual roots, with the potential to damage our profession, and is contrary to the best interests of the public at large.

I suggest that we work for the establishment of national standards of training and certification testing that will apply equally to all. While medical doctors who wish to practice acupuncture should certainly be allowed to waive elements of the required curriculum, they should not be excused from meeting the educational standards established for all other practitioners.

These are minimum requirements that should apply to all, in the interests of fairness and to ensure the safe effective delivery of acupuncture and related treatments to health care consumers. We should have no privileged class of practitioners who are exempt from the standards established for all others. Thank you.

DR. GORDON: Thank you.

David Molony.

MR. MOLONY: Good afternoon, Commissioners. My name is David Molony. I am an Oriental Medicine professional and executive director of the American Association of Oriental Medicine.

The Oriental Medicine profession is the most comprehensive, far-reaching, credible, and accepted CAM field of medicine in the United States. We have in place national education, accreditation and certification examination standards in acupuncture, herbal medicine, and bodywork.

An intrinsic part of our education involves patient education on wellness and self-awareness, which we feel expands to family members and friends. While public awareness on self-care can be part of an ad campaign, the most headway can be found in a positive personal experience with a practitioner or a close friend or relative who has had such an experience, as Dr. Brisbane stated earlier in a different way.

The expansion of Oriental Medicine in the United States has brought just such profound experience to the lives of many, and this has provided for the logarithmic expansion of our field with such rapidity that

it has continued to evolve into a field of medicine in its own right.

People using internal and external martial arts are understanding that balance is more than psychological homeostasis or physiological homeostasis. They know that, many times, simplification and a strictly personal understanding of the basic levels of human comprehension of concepts such as yin and yang, and the concept chi with its movement throughout life, provides a sense of health that can enhance one's ability to cope with any infirmity. This is not religion, but it works with any religion that is open enough to use it to enhance its well being.

Education in Oriental Medicine colleges always involve some form of development and manipulation of chi to provide for better treatment, and also for self-regeneration after treating. While this is not always consciously imparted during an acupuncture treatment, for instance, the shared experience provides a venue for observation of that movement and the acceptance of the qualities of chi that surround us. This is a very important aspect of an acupuncturist's interaction with patients.

Other aspects of Oriental Medicine that work well within a self-care model are over-the-counter herbal preparations with a simple understanding, similar to that used for over-the-counter remedies here in the United States. It is not hard, for instance, to differentiate between three or four cold remedies which will increase the likelihood of a rapid recovery, tenfold.

Undereducated countryside folks in China do this on an everyday basis with good results. I expect that we will see this sort of thing evolving to the norm over the next few decades, assuming that the public health is considered an overriding factor compared to fiduciary interests or dogma.

Diet is an important aspect, and we have certainly evolved away from the simple understanding of how we interact with nature by how we eat. Simple awareness of the hot and cold natures of foods relative to our state of health can provide a wealth of wellness information that can be used on daily basis to achieve a longer, more productive life and a less drawn out death.

Professional Oriental Medicine looks forward to working with conventional health care in the United States to enhance the well being of the public through the use of the oldest and most renowned longevity and wellness practices in the world.

DR. GORDON: Thank you.

Marcellus Walker.

DR. WALKER: Thanks for the opportunity to present to the Commissioners today. I am Dr. Marcellus Walker, a practicing board-certified internist and trained in multiple forms of CAM therapies over the last 10 years. I am author of the book "Natural Health for African Americans" and founder of the website africanamericanhealth.com.

I was a panel member for the NIH Consensus Conference Statement on Acupuncture in 1997, and am founder of the recently formed African American Health Foundation. This foundation is dedicated to the dissemination of best-practice information in conventional and CAM practices. It is also dedicated to direct research endeavors to resolve the existing health care crisis in the African American community.

We have talked a lot about special-need populations. This is one example of special needs. I would have to echo that we need to consider this both on the physical level as well as energetically. As we move

forward, as your commission moves forward, we need to consider that we may have populations that have different physical needs as well energetic needs.

What I have come to learn is that information is really food, and that when we present this information, if we view it that way, it is helpful. Therefore, part of our task is to provide a large amount of information rapidly to people, but we need to give them a relative warning about what they are to ingest.

My experience is that it needs to be presented as high-powered baby food and that the information needs to be easily understood and can be assimilated briefly, and at the same time allow them to understand what they are about to ingest. Therefore, I am proponent for us developing a rating scale of information.

As I listen to the challenges that you are dealing with here, one suggestion that I have is that we really need to develop two rating scales simultaneously, and that is because we exist as two systems, both as a physical body, and also as an energy system.

Consequently, at times, they seem to be diametrically opposed, but if we view them simultaneously and develop two rating scales, I think we can be able to look at information in a way that we can present in a logical way, and people can choose what they choose to digest.

I have put two rating scales in the back for you to look at, and we can talk about that later, if you would like.

What is most important, for me in my experience, is that when someone presents information, if they have a clear sense of what system they are working in; are they working physically; are they working energetically; and exactly where within that system they are working, that information has more merit, and therefore, should really have a higher rating on an arbitrary rating scale.

In addition, issues of side effects, selection criteria, issues of dosing, are also factors that need to be looked into. Thank you.

DR. GORDON: Thank you.

Diana Chambers.

MS. CHAMBERS: T.S. Eliot said "What we call the beginning is often the end, and to make an end is to make a beginning. The end is where we start from."

Given yesterday's focus on CAM in the media, I would like to testify, as I did in front of Commission last year, on the language of healing. I am concerned, as I believe are many of the Commissioners, with the language forms that are used in the discussions here, as I have heard numerous references to the inadequacy of the language with some frustration that nothing is available.

We live in a post-modern society. Post-modernism operates on the assumption that rhetoric is not descriptive of what is, but is generative of what is. It does not point to something that is there anyway, but in the moment of utterance, creates something that did not exist until the moment of utterance.

When something is said, the world is changed. Language leads reality. Whatever language the Commission uses in dialogue and in its final report will be highly influential in the ways in which the practices with which we are concerned are subsequently described.

I would like to challenge the Commission and its staff to take the embracing of accurate language as of central significance, to help shape the reality in which the practices with which we are concerned must operate, as opposed to living with the language that has been given to this point.

When I testified last year, one of the suggestions from the Commission was that we might seek a grant from the National Endowment for the Humanities to explore the language question. My plea is that you do not wait to make such a recommendation in your final report, but that you work with the language issue now.

All language systems only make sense if we are willing to accept them. The implication of the use of the words "complementary and alternative medicine" and, in my opinion, worse yet, the acronym "CAM," is that we have given scientific and allopathic language a privileged place in describing healing.

While CAM has become the accepted phrase in many circles, such language should not be allowed to dominate our dialogue as it is not universal language, which is especially obvious when global approaches to healing are considered.

So the question concerns what narrative we have to match the hard-fixed narrative of Western medicine, with its focus on fighting disease and cure. The alternative has to be elusive, or else we become as hard and fixed as the narrative of allopathic medicine.

I recognize that the problem with an elusive narrative is that it sounds as if we don't know anything in front of hard-nosed fact and reality. In my opinion, a more elusive narrative allows us to maintain our ethos and essence, and open space for continued dialogue. This is surely part of the wisdom of thousands of years of Chinese strategy on the matter, with Tao Te Ching giving many such references.

We need to find ways in the language we use to allow, not for lack of certitude, but for possibility and life. The language of technical medicine implicit in the term "CAM" is so inherently lifeless, and yet we are gathered here in this room today to talk about healing and life.

I urge the Commission to stand back and take a look to see if the language you are using is consistent with your real concerns and interests. Thank you.

DR. GORDON: Thank you.

Robert Miller.

MR. MILLER: My name is Robert Miller. I am manager of the federal office of the Christian Science Committee on Publication. I appreciate this opportunity to speak before the Commission.

Some of the testimony you have heard has been clearly about health care practices that center on spirituality. The term "spirituality" is used quite broadly today, yet even with this widespread application of the term, one important element of spirituality is often overlooked, and that is prayer-based healing.

As the Commission looks at various spiritual practices, prayer-based healing needs to be represented. Such healing is one of the most popular alternative remedies in the country. A recent survey indicates 44 percent of the general public have used prayer as an alternative treatment. According to George Gallup, Jr., 41 percent of Americans surveyed reported physical or mental healing as a result of prayer.

Prayer is recognized in many cultures as contributing to positive health care outcomes, which has stimulated research into spirituality in fields of medicine and psychology. I believe this research is moving us toward an expanding understanding of health in general, and self-care in particular.

It is certain that some elements of religious practice may appropriately be considered adjuncts to medical practice and behavioral medicine. However, this does not mean that prayer-based healing should be governed and regulated within the medical model. Although, there is obvious correlation between mind-body medicine and prayer-based healing, such as the importance of the thought of the patient, these terms are not synonymous.

Prayer-based healing has a very long history and predates the current interest in CAM. It has been accommodated for decades in the U.S. on what might be called a spiritual track within health care. Not every remedial method needs to be incorporated into the medical model. The system of self-care established by Alcoholics Anonymous is a good illustration of an approach that does not incorporate well into medical model. Christian Science is another.

It is a system of prayer-based healing that is explained in a reference book by Mary Baker Eddy, titled "Science and Health with Key to the Scriptures." This system of self-care has been successfully practiced over 130 years, providing both preventive and therapeutic benefits.

The Christian Science system of healing includes assistance for those in need, with practitioners, nurses, and religious non-medical nursing facilities for this available method.

The Christian Science healing is accommodated in law, health and disability insurance programs, and health insurance plans that cover state and federal employees. Part A Medicare provides coverage for nursing care given in religious, non-medical health care institutions, including Christian Science nursing facilities.

The Christian Science system is a modern-day illustration of free market and government accommodation for prayer-based healing without medical supervision, regulation, or control. We ask, therefore, that the Commission acknowledge a spiritual track in support of patient self-care and personal wellness. Thank you.

DR. GORDON: Thank you.

Kathleen Quain.

MS. QUAIN: Good afternoon, Commissioners. I am Kathleen Quain, president of the Foundation for Health & the Environment.

The extraordinary work outlined in Daniel Tobin, M.D.'s book "Peaceful Dying" is being implemented into mainstream health care, and could easily integrate with complementary medicine. Dr. Tobin's program is holistic, wide-ranging in terms of scope, and provides an opportunity in over 50 demonstration sites in national models with HMOs and multiple providers to use the advanced illness coordinated care model. Dr. Tobin is eager to integrate and collaborate complementary medical strength into the evolving model. Here is a descriptive outline and contact information:

The organization and dissemination of wellness reflects a new medical school curriculum that is

practical, easy to access and understand, and focuses on creating national as well as individual well being. Through information technology and with a wellness-centered emphasis, CAM educates people on how to reduce stress, fear, and levels of hate, highlighting the importance of breathing, laughter and joy.

Most diseases can be prevented if people understood how to create health. Every day, our bodies need nutrients, including vitamins and minerals. Obesity is a sign of body undernourished. If people ate food that was meant for our anatomy and physiology, many diseases would be eliminated.

In other countries, it is hard to find a case of Alzheimer's. Neuropeptides require nourishment. When the body's nourishment is depleted, the brain also does not have proper nourishment. Globalization has made the U.S. more vulnerable to exotic diseases. CAM bolsters worldwide medical practices and helps solve many of the medical problems that the U.S. is facing.

Here are some suggestions for organizing CAM information: List the diseases that Americans suffer from; offer the public successful, interventive information for each disease, starting with the least aggressive intervention to the most allopathic treatment; do a preventive seasonal program based on Elson Hass, M.D.'s work, "Staying Healthy with the Seasons," which balances Eastern and Western medical wisdom for Americans; strengthen the immune system through detoxification, imagery, prayer, peaceful relaxation, art therapy techniques, and the use of pressure points for the immune system; emphasize prevention by clearing out poisons before they make people ill; offer our nation's most effective programs that combine science and faith, art and technology.

Nationally, there are unprecedented cluster areas of autistic children in America. There appears to be evidence to show that considerable heavy metal content is present in the blood of an autistic child. Heavy metals can be non-toxically removed by using nutritional supplements that bond with the heavy metals and detoxify the pollutants from the child's body. Thank you very much.

DR. GORDON: Thank you.

Donald Epstein.

MR. EPSTEIN: Hello. Researchers with the University of California, Irvine, Department of Sociology and the School of Medicine have developed the revolutionary Patient Assessment Questionnaire for Wellness. This questionnaire exams the complex relationship between the patient, lifestyle choices, life stress, various demographic factors, both biomedical and social science measures of wellness.

Through self-assessment, it measures physical well being, emotional well being, stress and life enjoyment, and an overall quality of life. The first of several papers has been published pertaining to wellness and its relationship to network spinal analysis, a system which I have developed. Additional papers will be presented in the research conference.

The use of this instrument is not limited to those having symptoms or ailments. It is applicable to a wide range of schools of thought on wellness. Its use for measurement of self-reported health and wellness is detailed in the articles that were submitted.

The physician is skilled in knowing about the progression of disease, but it is only the patient who truly knows about the internal experience of health and wellness. In fact, a person's report of her own health has been shown to be one of the strongest predictors of her mortality.

Effective wellness outcomes are essential. Practitioners who care for individuals are being charged with excessive or inappropriate utilization, in spite of individuals continuing to achieve increasing levels of wellness under a practitioner's care. The consumer and the practitioner, alike, must have the freedom to choose a wellness approach with specific wellness outcomes to our health without being engendered legally, financially, or politically.

Ineffective care must be distinguished from care that does promote overall health and wellness without the sole attention on the particular presenting symptom or complaint. I know patients who continue to report pain, in spite of the fact they stopped drinking, smoking, or abusing family members. Others, no longer accept the destructive aspects of their life as being normal.

Some people with advanced cancer are now feeling more alive, productive. Others, who may have serious disease, but the person doesn't want to think this serious, they are living a full life. The inner experience is what determines whether a person is ill or well. Treating diseases does not promote wellness. It does not release the illness which is about the person.

Wellness is the experience of wholeness, invincibility, flexibility, openness to life, and an ability to feel alive. Disease has little to do with the individual per se, or their life. It is about classifying conditions. Wellness is distinguished by a richer experience of life, hallmarked by choices which are more productive, efficient, and bring greater life fulfillment.

Outcome assessments for wellness must incorporate such markers for healing. By redefining desired outcomes, clinical approaches can be refined to better fulfill the patient's needs and create a new standard for health and wellness care. Thank you.

Panel Discussion

DR. GORDON: Thank you. I am reminded, listening to you all, of how grateful we are to have really distinguished people come and take their time, and be here and speak to us. So I really appreciate your perspectives.

Questions from the Commissioners? Ming, go ahead.

DR. TIAN: I have a question for Dr. Zeng, and also for David.

I think it is very important that you brought an issue to have a national standard, establish a standard of acupuncture and Chinese Medicine. My question is, in your opinion, to train as a Chinese medical doctor in China -- I understand you have an M.D., and also an O.M.D. -- how many hours were you trained, both Western and traditional Chinese Medicine?

DR. ZENG: I was first accepted as a medical doctor 25 years ago, but in China it is six days a week and a 40-hour week. When the internship, which is six days, and every is eight hours. So, total hours, I believe, is about 6- or 7,000 hours for medical doctors.

In Oriental Medicine, doctor training is five to six years, by my best analogy so far. Also, it includes about 5,000 to 7,000 hours.

DR. TIAN: Thank you. The second question is, when you mentioned the standard and you brought the

definition of traditional Chinese Medicine, which includes Chinese herbal medicine, acupuncture, bodywork, and other things included.

When you set up the standard, or establish the education or standard for licensing, then do you want to do that separately, or do you want to do one? Like a doctor of traditional Chinese Medicine, how do you handle that?

DR. ZENG: So far, in the country, we have two programs going on, which is an acupuncture program and an Oriental Medicine herbal program. Both belong to the Oriental Medicine or Chinese Medicine. The testing we have with the NCCAOM already existed over, maybe, 18 years now, which is including the acupuncture certificate exam and the Chinese herbologist exam and the bodywork exam. In the future, maybe some can be combine.

DR. GORDON: Thank you.

DR. CHOW: Thank you for all your presentations. It was inspiring. I also have a question for David and Dr. Zeng.

You talk about yin and yang, and the energy. In the practice of Chinese Medicine, and as I understand it, with some of the other cultural practices, like Ayurveda medicine and so forth, the emphasis on the energy concept -- in Chinese it is chi -- what is the difference, and is there any difference between just learning a cookbook recipe, which some people are, in to, say, this disease and you use these points, without the consideration of the energy concept, et cetera.

Can you discuss that pro and con concept of that. Is the energy concept essential for the practice of wellness in the practice of Chinese Medicine?

MR. MOLONY: With Chinese Medicine, one of the most important things is understanding what chi is, and that is an experiential process that can only be learned through extensive training and practice. That is why, in an acupuncture/Oriental Medicine school, at this point, a fairly large number of hours are spent in clinical practice, because it is learned through training. Many say it is even learned after a few years of practice. It is something that is experiential.

The understanding of yin and yang, and of chi, can be experienced as far as a patient, in a wellness way, fairly easily by personal experience on themselves. As far as giving that experience to somebody, that is where the training comes in.

So that is the differentiation there. A questions gong practitioner like yourself could teach somebody how to manipulate their own chi in a very good way, and practitioners are usually trained on how to do that, as I said, but being able to teach somebody how to do it does require more training.

DR. ZENG: By my best analogy, the Oriental Medicine and the Western medicine, both systems have a little difference. Western medicine is fundamentally in biomedical science, and is very exactly provided by testing or x-ray. It is a very scientific.

This treatment is more subject to the exact purpose. The Chinese Medicine is based on the experience and the non-historical, the human being fighting with diseases. We have a systematic theory which is focused on distinguishing the syndrome, not like Western Medicine which is focused on distinguishing the disease.

So they have some differences but I believe in the future there will be some kinds of combined to bring a higher level. Also, the Chinese Medicine is focused on integrated physical, psychological, and spirituality together. I like the speech that said, "Chinese Medicine is more focused on preventing rather than the cure. So that kind of philosophy, I believe, personally, that is very true. In the future, we will be paying more attention.

MR. MOLONY: In just one short sentence I will say that the equipment used in scientific medicine has not been developed yet that is nearly as subtle and as aware as the human practitioner's ability to discern things.

DR. CHOW: Thank you.

DR. GORDON: Thank you.

Tieraona, do you have a question?

DR. LOW DOG: Diana, we actually spent lunch today talking about language. It was kind of interesting. Part of it, also, was we sort of had a mandate which said complementary and alternative medicine. So that was part of the charge of the Commission, but we are discussing, actively, definitions, not changing the title, but looking at descriptions, perhaps.

I was wondering if you had any thoughts or ideas, other than how you would define, describe, or other language that you would use for complementary and alternative medicine. Dr. Jonas provided lots of think tank groups that spent a lot of time, and I understand when you say complementary and alternative, you have sort of assumed that Western medicine is the paradigm, and everything is outside of that, but how else would you go about defining? And do you have any ideas?

MS. CHAMBERS: At Friends of Health, the phrase that we are choosing to use at this point, and it is in process, is, we are using the phrase "whole-person health," whole person including body, mind, emotions, and spirit. And we are saying health as opposed to medicine, recognizing that we are interested in health and well being as opposed to just fighting and curing disease.

So that is the overarching phrase that we have chosen for now, and if something else emerges that actually is more comprehensive, that we can embrace, then we would cheerfully do that.

DR. LOW DOG: I love "whole-person health." I think part of the problem that we are encountering is trying to define part of the scope of what this commission was asked to do, as far as looking at acupuncture, and looking at massage, and looking at mid-wifery, looking at many, many modalities. Whole-person health also includes surgery, and it includes general practice and family medicine.

So it includes all of those things because that is not coopted by any one group of people. So we run into the difficulty of trying to define, maybe the indefinable, I think you mentioned, an umbrella term for so many modalities. I think we are coming to that same place. You see what I am saying?

Whole-person health is wonderful, and using "health," all of these things, but it makes it difficult to try to define what we are trying to do for the American public, and to the consumer, when we are talking about access, reimbursement, people having more opportunities to participate in these. In some way they have to be delineated because they already are by the government and reimbursement systems.

The most funny thing, I think, that most of us feel is, and you may agree, that the consumer doesn't really differentiate them. Most people don't say, "I am going to my CAM practitioner." They say, "I am going to my acupuncturist," "I am going to my chiropractor." They don't make these arbitrary terms, but we sort of have to.

So any ideas that you have, if you could take your great mind to think about it and pass them into us, I think we would appreciate it.

MS. CHAMBERS: Thank you. I think that it is fluid, and I think one of the discussions I heard this morning, one of the general ones, is that it is to do with where power lies, and it is to do with what is excluded from the system right now. At the point where something becomes included, it will no longer be CAM, so to speak, because it will have the power to be operative.

So as things become included, the definition and what is included within whole-person or CAM will keep on shifting.

DR. GORDON: I wonder if there are other panelists who have some thoughts about this question of definition and language. We really would welcome hearing from you.

DR. WALKER: I would like share on that issue. I think it has to do with issues of directionality. For example, the word "whole-person" or "integrated" moves us in the direction of being one piece versus the word of "complementary" sounds like the two pieces that stand next to each other, and "alternative" means there is a split.

So I think that we do need to have an intention of where we are moving towards, and so I would support the issue of "whole-person" or the issue of "integration" versus "complementary," which means that our two parts of ourselves are not together. So it becomes essential, when we are talking about wording, to really honor where we are going.

DR. GORDON: Let me ask you a question about "integration." If "integration" implies that some things are coming together as well as a whole, how does that deal with systems of health, including traditional systems, that don't particularly want to be integrated? Or, at least not integrated with others, even though they may be integrated within themselves.

DR. WALKER: Right. Well, I think it has to do, again, with the space they are occupying. For example, in the past there have been people that have viewed themselves as alternative. Maybe they are an alternative homeopath, or they practice only acupuncture. They are viewing the world from themselves as energy back towards a physical. So it has to do with how they are viewing things.

I think the task here is for us to take the larger picture, which is, where are we going, and then with that as an intention to pull it together. Ultimately, a person has to make a choice. So for the information practitioners, they can choose to be part of a whole or to remain split. It is up to them.

DR. GORDON: Great.

Yes, Don. Last thing.

MR. EPSTEIN: Another concept would be intrinsic healing, because I believe what is happening here is

that different people are suggesting that the healing itself is an intrinsic property of life itself, and that each person has a different strategy towards that.

I think another thing is that the question is

-- it wasn't thrown out but something to think of -- is the person you are taking care of truly a patient, because it is not just the practitioner we are doing, but who you are taking care of. It is the patient. The term "patient" implies someone who is passive in the process and someone is going to fix them, as compared to somebody who is participatory.

Dealing with the public, I think that if you deal with what the system is called, you need to look at outcomes for it and you need to have another term to describe the participant that parallels it. Otherwise, the participant has the same expectations of the language as a patient.

DR. GORDON: Does that lead you to "intrinsic healing," or does it lead you to another word?

MR. EPSTEIN: I would say "intrinsic healing," and I would refer to a patient as a practice member rather than a patient, just to make a distinction in the outcomes, because I don't want to have it just for what the practitioner is, but what is the consumer.

DR. GORDON: Great.

Other thoughts? Yes, Kathleen.

MS. QUAIN: The words and images that embody your focus, your creative focus of what you are trying to achieve, can be brought out to the people, and the spirit of the people usually grows and leads. That would help with resistance to CAM philosophies.

DR. GORDON: I'm sorry, the word what?

MS. QUAIN: The words and images that you use to portray CAM in a creative development, if you are putting this all together in a whole, that energy is energy medicine and can be based on health principles, and be medicine to make contact with the people.

DR. GORDON: Can you make that spirit a fleshly word? What word does that suggest to you?

MS. QUAIN: Well, I think there is a whole vocabulary for this based on ancient principles of health that people respond to in health, or they shut down. If you look at what happens on television with horrific images and what that does to us inside, and also with the pacing of quick visual digital images. Children's programming is designed to create hyperactivity.

So we can reverse this, also, through the images and the words.

DR. GORDON: Thank you.

Yes. Diana?

MS. CHAMBERS: I think, also, not just the actual language but the language forms are really important too. So things like poetry and drama and metaphor, they all are vehicles for possibility, as opposed to

just being grounded in certitude. They open things up.

I don't know how many people were fortunate to see the HBO production of "Wit" at the weekend, but that is the perfect example of how John Donne's poetry was interwoven into this dying process, which was a wonderful education for how we should look at our mortality, our living and our dying.

There was an incredible reflection on his poetry about death. Let me see, "Death be not proud, though some have called thee mighty and dreadful, for thou art not so. For those whom thou dost overthrow, die not poor death; nor yet canst thou kill me."

There was a reflection in this production about how if you use a semicolon or a common, it changes John Donne's meaning, and it draws a firm veil between life and death, or a very fine one. It was an extremely powerful production.

So if we could find ways to incorporate these other forms, as opposed to just different language, I think we would be opening the dialogue up, and keeping it as a dialogue instead of closing it down.

DR. GORDON: Marcellus, you will have the last word.

DR. WALKER: I am kind of the integrator. I am in the middle here, it seems like.

I want to reflect what I am perceiving, which is, she is speaking from an energetic point of view, as are you, in terms of when people read information, for example, metaphor, that is really energy body language. Whereas, as scientists, we are speaking more as a physical body position. So what we put out needs to really be in both languages, so that, depending on your orientation, you can perceive it. Okay, that is baby food.

So you need to be sensitive to who your audience is and present it to them in both ways, so that they can get the essence of what you are saying.

DR. GORDON: Thank you. That is very helpful. Thank you all. We will seat the next panel now. Thanks again.

MS. CHANG: Would the following speakers please come up and be seated: We have Lisa Stancik on behalf of Paula Kim, Jennifer Roe, Scott Lamp, George Kurtz, John Adams, Bruce Nordstrom, and John Melnychuk.

DR. GORDON: Veronica, excuse me. I understand I missed your hand, so you have first this next time.

Lisa Stancik.

MS. STANCIK: Good afternoon. My name is Lisa Stancik, and I am here today as a volunteer representing the Pancreatic Cancer Action Network, otherwise known as PANCAN. PANCAN was founded in 1999 as the first and only national advocacy patient benefit organization for pancreatic cancer.

We are moved into our second year of service. Our handful of inaugural grassroots volunteers has grown to become a staff of three, along with thousands of volunteers united across the country, known as PANCAN Team hope advocates. We are working with everyone to increase awareness and bring

attention to urgent need for well-designed medical research with positive outcomes.

Pancreatic cancer is the fourth leading cause of cancer death for men and women in this country. Twenty-nine thousand Americans die annually from this horrible disease. The typical pancreatic cancer patient is diagnosed with Stage 4 metastasized cancer and has a life expectancy of a mere three to six months. I personally know this devastation, as I watched my mom's life taken away by it.

Pancreatic cancer has absolutely no early detection method. Treatment options are severely limited and generally palliative. Pancreatic cancer has the highest mortality rate of all cancers. The common symptoms of pain, severe weight loss, and fluid retention become quite overwhelming and tough to manage as the disease its course.

As you can see, the pancreatic cancer community desperately needs your help, and we are interested in safe and effective methods. We thank you for initiating discussions and our ability to join with you all in this. Many people, however, perplexed about complementary and alternative medicine.

On one side of the fence, folks wonder why more people don't use complementary methods. Many people swear by these methods. Methods are older than the country, and multimillions of dollars pour into treatments and products that rely on personal and anecdotal experience.

Then on the other side of the fence, these folks wonder so many people use complementary methods, methods that are unproven and not validated through accepted scientific practice. There is no oversight or safety mechanisms to protect the consumers, methods that are often referred to as the modern-day equivalent of snake oil.

Regardless of the side of the fence that you are on, the fact remains that the use of complementary and alternative practices, whether alone or combined with traditional methods, brings more questions than answers exist.

These are the questions that when answered will bring opportunity, an opportunity to develop well-balanced and combined approaches that keep patient protection and safety at the forefront while the science of these methods is researched and validated, an opportunity to develop the critical and necessary information through further meetings through scientists, researchers, and patients actually going through this, is what we recommend. Thank you.

DR. GORDON: Thank you.

Jennifer Roe.

MS. ROE: Good afternoon. My name is Jennifer Roe, and I am the director of Membership and Publications for the American Association of Naturopathic Physicians.

The topics covered at this meeting concern the public's need for CAM information, self-care, and wellness. Germane to these topics, I would like to suggest some policy recommendations on behalf of the AANP.

Allow patients to have equal access to all licensed provider types, and allow licensed providers equal opportunity to participate in all federal health care programs.

Fund research centers at CAM institutions to help support the necessary development of research and academic infrastructure.

Encourage the formation of a coalition of licensed and emerging CAM provider groups to work together on CAM information development, dissemination, self-care and wellness, as well as other objectives of the Commission.

Toward this end, we urge the Commission to call for the establishment of an office on CAM and integrated health care at the assistant secretary level at the United States Department of Health and Human Services, with the authority to oversee, coordinate and direct all federal CAM activities through this office.

Prohibit distance learning programs from awarding doctoral degrees in naturopathic medicine. These degrees create a false impression in the minds of the consumer that the provider of health information is in fact a doctor, when in reality, he or she has had no clinical training whatsoever, has not passed a licensing examination, and does not hold a medical license.

A recent tragic example provides a painful illustration of the consequences to safety with such an unlicensed individual.

In October of 1999, an eight-year old girl, who was an insulin-dependent diabetic died because her mother was convinced by a mail-order degreed, self-proclaimed doctor of naturopathic medicine that he was providing safe and effective care for her daughter.

This man, who displayed a diploma from a correspondence school selling so-called doctoral degrees in naturopathy was apparently not educated enough to understand that an insulin-dependent child cannot be taken off her insulin and treated with herbs. The mother trusted, the child died, and the man is charged with manslaughter.

This unfortunate event took place in Asheville, North Carolina, where there is, as yet, no licensing for naturopathic medicine. I encourage the Commission to take the opportunity to ensure no similar disaster befalls any other American family by lending assistance to the promulgation of appropriate, uniform professional standards, including regulation by licensure to the CAM community.

In conclusion, I would like to encourage the media, government, and other agencies disseminating CAM information to utilize the expertise of licensed naturopathic physicians in developing such information. That AAMP has an established network of physician members who are available for providing information on CAM to media, governmental agencies, and policymakers. Thank you.

DR. GORDON: Thank you.

Scott Lamp.

MR. LAMP: Good afternoon. My name is Scott Lamp, and I am chairman of the Healthcare Integration Committee for the American Massage Therapy Association.

Due to the recognized health benefits and low cost of massage, massage therapists have become primary providers of wellness-oriented therapy for people who are considered healthy by most standards.

From my experience, today's clients expect to receive information on self-care from their massage therapist, and most massage therapists feel that part of their job is to educate their clients regarding general wellness issues.

In doing so, therapists must stay within their defined scope of practice and not dispense specific medical advice. However, in Ohio, for example, education is considered outside the scope of practice of massage therapy, clearly blocking the flow of information.

How can practitioners be expected to help a person with neck tension and not discuss with them the cause of that tension or recommend simple techniques to gain relief? In our efforts to restrict non-medical health care providers from prescribing specific medical protocols, we must be sure not to unduly restrict discussion between CAM practitioners and their clients regarding general health and wellness practices that are ubiquitous in the media.

I urge the Commission to include in its recommendations that any health care provider be allowed to discuss generally recognized wellness practices, such as taking warm bath, without fear of being charged with practicing medicine without a license.

As we integrate more with the mainstream health care delivery system, many therapists worry that medically oriented massage will place an added burden on those therapists with cash-based wellness oriented practices. We must not allow the escalating costs and professional requirements associated with medically oriented care to interfere with providing low cost, wellness-oriented massage.

There seems to be little interest, and even less money, for research into wellness-oriented therapies that do not retail a product. Who will fund research to provide the healthy with continued good health? How will we understand the cost benefit to our society of promoting healthy lifestyles?

A massage therapy research agenda has been developed by a workgroup of the AMTA Foundation. They have noted that the effect of regular massage on a healthy population has never been formally studied, and recommended that this study be a priority.

In closing, I would like to thank the Commissioners for their effort and remind you that AMTA serves as a reliable source of information to the media and consumers regarding massage therapy. Anyone can visit our website, amtamassage.org, and we are currently exploring methods to better serve as an information resource for the medical community and the insurance industry.

As chairman of AMTA's Health Care Integration Committee, I would welcome any suggestions offered by the Commission in this regard. Thank you.

DR. GORDON: Thank you.

George Krutz.

MR. KRUTZ: Thank you. My name is George Krutz, and I am president of the Feldenkrais Guild of North America. I would like to take this opportunity to present some thoughts around the ideas of health, education, and self-care from the perspective of a Feldenkrais practitioner.

Galileo said, "We cannot teach people anything; we can only help them to discover it within themselves." The Feldenkrais Method is a system of somatic education. It is not prescriptive or

authoritative, but experiential, in that it is based on careful and systematic observation.

Practitioners engage with their students in collaborative research projects. Through the use of movements, students become aware of their patterns of action and the possibility for change. This sense of self-discovery continues long after the session is over.

The Feldenkrais teacher does not transfer knowledge, but instead sets up conditions for learning. The student does not learn a procedure or a protocol. Instead, they develop a more refined sense of themselves and their capabilities.

The Feldenkrais practitioner works from the viewpoint that function can be improved, regardless of the level we find it. The approach is the same whether working with a world-class athlete, or a neurologically impaired infant. Any improvement in function results in greater freedom, autonomy, and dignity.

The Feldenkrais Method is not a medical approach. It is an inquiry into and an application of the fundamental processes of learning. It is a valuable resource for the medical community and for those who are in their care, but it is also used in primary and secondary education, the performing arts, athletics, and business.

Moshe Feldenkrais held the view that health was not pathologically based. Health is the ability to adapt and respond to the environment in order to fulfill one's needs and desires, to enact our avowed and unavowed dreams.

I would urge the Commission to consider this perspective of health. It would, I believe, allow for a truly complementary relationship between medicine and other disciplines. Not all health practices are medical. I would like to suggest that integration does not imply absorption.

Specific recommendations I would encourage are: That the Commission adopts a stance recognizing and respecting the authority of people's judgement and experience. This is the core of self-care.

That the Commission considers carefully the effects and implications of the language it employs.

That the Commission encourages the use of learning tools such as the Feldenkrais Method in the education of doctors and other health care professionals. It would provide not only an experiential component to complement their training, but also a valuable means for their own self-care. Thank you.

DR. GORDON: Thank you.

John Adams.

DR. ADAMS: Hi. I am Dr. John Adams. I practice chiropractic in Colorado.

Drug reactions and medical mistakes are the third leading cause of death in United States, killing more people than handguns and car accidents. As a nation, we spend \$76 billion a year cleaning problems that medical drugs cause. We rank near the lowest of all countries in morbidity and mortality, and yet the federal government invests \$7 billion a year to train medical residents, and gives several billion dollars a year to medical schools for research.

Alternative health care, on the other hand, is extremely safe, cost effective, and gets people well. One need only look at a comparison of malpractice insurance rates between a doctor of medicine and a doctor of chiropractic to see how much safer a non-invasive approach is.

There are numerous studies validating the effectiveness of natural health care. A retrospective study of nearly 3,000 patients of network spinal analysis practitioners is a perfect example. Over three-quarters of the patients studied reported improvements in all categories assessed, including improved physical state, improved mental and emotional state, improved response to stress, improved life enjoyment, and improved overall quality of life.

If a safer and more effective choice for health care exists, why don't the majority of Americans use it? I believe it is due to generations of drug advertising and television programming. From "Marcus Welby, M.D." to "ER," Americans have been taught a faulty paradigm for decades. They are saturated with the idea that health comes from the outside, and nearly always in the form of drugs and surgery. How do we change this? Through the same medium, television.

My first proposal is that we stop advertising drugs the same way we stopped advertising tobacco and alcohol. Surely, the statistics show that drugs are deadly. Why not treat drugs for what they are, and stop portraying people who take them as intelligent, sophisticated, and healthy.

My second proposal is that we teach the public a new concept wellness through a television drama series, featuring and teaching alternative health. Currently, the federal government pumps billions of dollars into a failing medical system. Why not take a small fraction of that money and invest in an exciting and innovative program that demonstrates that true health care begins well before it disease starts.

This show can teach people that a new, exciting form of health care exists, one that acknowledges and assists their body's innate intelligence to help express their true health potential. I challenge anyone here to find a faster, more effective and affordable way to change the health paradigm of this nation.

I have written an novel called "The Power." It is a suspense thriller featuring chiropractic. I have given each of you a copy. I hope that you will read it and enjoy it, but more importantly, see it as an example of the type of educational entertainment that could help reinvent our nation's health care system. Thank you for your time.

DR. GORDON: Thank you.

Bruce Nordstrom.

DR. NORDSTROM: Thank you for allowing me the opportunity to be here again today. I am here representing the American Chiropractic Association.

As the saying goes, an ounce of prevention is worth a pound of cure. With that in mind, I urge the Commission to ensure that the promotion of wellness is included in its final recommendations to Congress. It is our understanding that the Commission may be considering the development of a consumer-oriented alternative medicine division within the Department of Health and Human Services. The ACA strongly supports this concept.

The Commission could recommend that Congress appropriate sufficient funds for the division to launch

a wellness campaign. In the era of increased consumer access to health care information via the Internet and other vehicles, there are many conflicting reports on the efficacy of many CAM procedures. A federally funded campaign on wellness could address these misleading reports. As we all know, the information is just voluminous, and someone to help show people how to address that would be very helpful, I think.

Such a wellness campaign could have many facets, including but not limited to targeting the insurance industry, the workplace, and also basic education at the elementary school level.

For example, a wellness campaign that targets the workforce could focus on the statistics that show that although safety and wellness come at an up-front cost, a more user-friendly work environment reduces risk and fatigue. Therefore, prevention and wellness not only decrease overall costs, it also protects their most valuable resources, their employees.

The insurance industry could be targeted with the message that wellness works. Once payers and their policymakers see the bottom line cost savings realized by those who embrace a wellness concept, one would hope that they would provide early and regular wellness interventions to those they insure.

If consumers are to embrace the concept of wellness, it must start with the children. In the wellness context of basic health care education, the wellness campaign could be targeted to ensuring that students be introduced to the whole spectrum of health care practitioners and their services, not just traditional medicine. This could go to the extent of computer education on the basics of ergonomics. We are potentially generating a whole class of people with carpal tunnel syndrome at way too early an age.

I would just like to quickly add that I also want to agree with the concept discussed by the previous panel, that language is important and we should avoid anything that promotes a "we" versus "them" mentality. Thank you.

DR. GORDON: Thank you. That is always a good reminder. Thanks.

John Melnychuk.

MR. MELNYCHUK: Hello. I am John Melnychuk, president of the California Health Freedom Coalition. We are working for a not-for-profit consumer group, which is working for health care reform in California. We represent consumers in California who would like easier access to all types of quality forms of healing practices.

Thank you, Commissioners, for your hard work and for welcoming me here today. It is nice to be here where we can all count on the lights remaining on.

Three of the greatest problems facing American health care for consumers are limited access to high-quality health care services of any sort, the expense of the limited choices available, and the lack of success of a one-size-fits-all kind of medicine.

One of the most serious problems facing Americans as they look for better solutions to their health care is that of access. It is not only money here that limits people from accessing the health care that works for them, it is also the illegality of alternatives in many jurisdictions.

The standard of care and prevailing practices rules prevent many licensed providers from offering

something beyond conventional treatments, which can't always help everyone. The laws which define medicine as "any healing and diagnosis," also limit access to people to complementary and alternative healing practices by making it illegal for talented, non-medically licensed healers to provide services. The hostile working climate for non-medical healers prevents them from working, and this limits access for all. Consumers, then, are prevented from seeing these people and assuming responsibility for their own health.

There is a tremendous reliance on the thought that someone else, usually doctors, insurance companies, or the government, via the Food & Drug Administration or the Federal Trade Commission, or other agencies, will and ought to care for any individual's health. It struck me yesterday, when we heard testimony from the FTC and the FDA, that they have developed their regulations with a great deal of logic, but very little common sense.

After yesterday's discussion, I am more doubtful of their effectiveness in looking after my interests. Science, of course, is important, but after all, health care disciplines as a group are known as the healing arts.

Where, then, should the burden of responsibility lie for any citizen's health? We at the CHFC think it should lie within the citizens and the health care providers, and not with the regulatory or enforcement agencies. We at the CHFC don't think it is a good idea to mandate standards and licensing boards for every single discipline. It is boggling to consider such a thing.

Many of the problems with health care in America have come precisely because of the design of the current health care system and the overwhelming legal advantage that allopathic medicine holds. If allopathic medicine is the most scientific of all medicines, could mandatory government-regulated standards be possible for all other disciplines? If this could happen, would it be a benefit to the public? I don't think so.

Part of why we are here in these meetings is to try and come up with better ways of helping the public become more healthy. More licensing boards will not help Americans become more healthy. Thank you.

Panel Discussion

DR. GORDON: Thank you. Thank you all.

Veronica, do you want to begin?

DR. GUTIERREZ: My question was originally for the last panel, which, I invite them to write a response but invite this panel to respond as well.

I couldn't agree more about licensing boards not helping Americans become more healthy. As we progress further in the discussion of wellness, I can see where there is going to be some problems along that line. So what I would like to know is what tools do we have out there, first of all, to measure the effectiveness or ineffectiveness of wellness care? Are there outcome assessments tools available? And more of a rhetorical question, when has wellness been achieved, in your opinions? And at what point, if any, should steps to achieve wellness stop?

DR. GORDON: Please, anyone respond.

MR. MELNYCHUK: Well, I would first say that wellness should never stop, that working toward wellness would never stop. This is probably one of the deeper problems that we face when, as Feldenkrais practitioners, when we interface with the medical community, because there needs to be a termination point, and we see learning as a lifelong, ongoing process. So I would say that that is a key problem.

In terms of outcomes, it is difficult to find the right things to measure without trusting people's experiences. Everybody's recovery, everybody's experience is basically anecdotal, whether or not it fits into a statistical model or not. So that is another concern. We are developing outcomes based on people's experience that we hope to be able to present at a future time.

So that is my part of it. I will let somebody answer the rest.

DR. ADAMS: I would like to add, also, that I believe that wellness has not limit as far as the ability to keep improving. That is one thing that the chiropractic profession has struggled with, is that if a patient continues a chiropractor's care, then it appears as over-utilization. Yet, in the retrospective study that I mentioned, with network spinal analysis, they studied several patients up to three years, and they found no ceiling to the improvement on these patients by their feedback.

DR. GORDON: Thank you.

Tieraona.

DR. LOW DOG: I have a question for John and Ms. Roe.

The whole Minnesota bill was just passed, which was very interesting. I think a lot of us are looking at this with freedom of access and that. I think it is too soon to know how that is all going to play out, but a very interesting bill.

I am struck a little bit by the accusations that Western doctors often have, that, "We don't want anybody infringing upon territory; that is part of why we are so anti." Naturopaths, I think, have to be careful of some of the same accusation, licensed and other people infringing upon that territory.

And yet, trying to balance that all with safety and licensure. The two of you are sitting next to each other. I would just like some comment from both of you, since you brought up the case of this child that was injured. That may have been fraud or misrepresentation, but I would like to hear both of your comments, since they are both sort of diametrically opposed.

MS. ROE: Well, first let me say that I am here on behalf of the Executive Director, so I really don't have a lot to say, other than the fact that she not only was injured, she died. In fact, she is no longer living. I know that it is a big issue for the AAMP, but I am not a doctor. I really don't have anything else to say. I am really just here on behalf of the Executive Director because she had to go to Florida for family issues. So unfortunately, I can't offer any more than that.

DR. GORDON: Okay, thank you.

DR. NORDSTROM: One of the things I would think of is that licensure doesn't guarantee that there won't be errors in clinical judgement from time to time. An environment of common sense is probably more helpful than anything. It is very unfortunate to hear the story of this child and this family, but I

would think that licensure for naturopaths may not have prevented this particular tragedy. Medical physicians were available in Asheville, and the mother of that child could avail herself of medical services if necessary. It is unfortunate that she wasn't encouraged to do that, or to see the necessity of doing that.

Part of the concern about licensure, it is not about clinical judgement. It is about a legal right to define a scope of practice. That is more the issue, actually, in terms of our particular objection to the term "licensure," because once somebody defines the scope of practice, that usually means that it grants exclusive right to a particular activity, and there is a large body of unlicensed practitioners in California who are making a career, and make their contribution without being licensed.

If there are more licensing boards, it will be difficult to manage. I would say very expensive, and not necessarily more effective than what we have now, in fact. I would let the consumer take more responsibility for their own choices.

DR. GORDON: Thank you.

If other panelists would like to respond, that would be fine too.

MR. LAMP: I would just like to add that licensing for massage therapy has been extremely successful. In California, where there is no licensing in the state, the consumer has a hard time distinguishing between legal or illegal prostitution. I don't know whether it is legal or not because they have no licensing, but the fact is that it is hard to distinguish.

And so, massage therapists have to go out of their way to word their ads by saying by extremely professional, non-sexual, all these words. So licensing has helped that in other states, and the public knows what they are getting or where they should go for what they are looking for.

DR. GORDON: Please, Lisa.

MS. STANCIK: Just jumping back to what Veronica had said, from the cancer community standpoint, as a patient advocate, we are very interested in getting validation, validation in terms of results.

Is there some way you can all come up with how you do measure some of these results? I will toss out an example. One of the ladies who I had hoped to bring here today has pancreatic cancer. She has been treating it with every clinical trial possible, but at the same time, using herbs, and now acupuncture, because that relieves the pain because the mets have gone to her brain.

Now, she is experiencing a lot of pain relief. So she has taken both of these kind of methods, as an example, into her own life. We absolutely have to get back to the validation.

In the first go-around, you were looking for words which might include all of this, and one word that I came up with, which I didn't hear around the table, is, "comprehensive" approach to healing. "Comprehensive" is what comes to my mind.

DR. GORDON: Good. It has come to my mind, too. Thank you.

Wayne, and then Joe.

DR. JONAS: I just want to get a clarification from Dr. Adams.

You weren't associating or assuming that because malpractice rates are lower in one profession, therefore it is safer? That seemed to be what you were implying. Is that what you are saying?

DR. ADAMS: Basically.

DR. JONAS: I think that is completely false. I just wanted to say that.

DR. ADAMS: Why?

DR. JONAS: Absolutely. I mean, malpractice is a legal phenomena that has to do with patient satisfaction more than anything else. It has nothing to do with safety. In fact, the risks are higher with a lot of therapies that are used for very severe problems, such as pancreatic cancer. So those individuals treating those types of patients are going to be inherently at higher risk, and their therapies are higher risk. So it may or may not have anything to do with malpractice.

Anyway, I also have a problem with this concept of wellness, especially the unlimited nature of wellness. Wellness, perhaps as a process or the process of continual self-repair, call it continual self-healing, is unlimited in the sense that it is ongoing, but I have a real problem with this concept of unlimited wellness, that you can always get there, higher and higher, better and better.

I mean, that is kind of the myth that is perpetuating, I think, a lot of the health care industry and is what Ivan Illich talked about in terms of the expropriation of health. Also, it blurs the lines between health-illness treatment and enlightenment and mortality. I am not sure we are talking about the integration of enlightenment procedures into these, but if we are, then perhaps we need a lot more discussion about this.

DR. GORDON: Or less.

DR. JONAS: Or less, right. Less discussion.

[Laughter.]

DR. JONAS: And we should decide immediately which one should be reimbursed for.

So I have a real problem with using wellness as kind of an unlimited concept. I have a problem with wellness itself. I think that there are ways in which we can support normal healing processes, and that we can stimulate healing processes, and that can lead to improved function, a sense of wellness, well being, better function, that type of thing. This can be an approach to treatment of diseases as well as enhancement of health.

But I would have a problem with saying that anyone who is a wellness practitioner should have their services reimbursed in some way, and that it is an unlimited concept.

DR. GORDON: Any responses?

DR. ADAMS: I would like to say a couple things. No. 1, I think living in our society today, because of the large amount of toxins in our food and our air, plus chiropractic is based on the principle of

removing what we call subluxation from the spine, which is a recurring effect from our environment, if we continually keep the spine clear and keep the person detoxing their body, seeking the right nutrition and things like that, then they are continually improving themselves.

There may be a limit, once it is all measured and done, but I think without continued care, people will go downhill, eventually.

I wanted to say something about the last thing that you said, but I forgot what it was. Sorry.

DR. GORDON: George, do you want to say something?

MR. MELNYCHUK: I wasn't trying to imply that there was not limit to what we can do. I was trying to imply that we usually don't know what those limits are. One of the things that I would like to use as an example is, I work with a lot of people who have had strokes. After six months, they have been told that whatever impairments they still have, they should just learn to live with it. A lot of those people make significant improvements, just by continuing.

There is no limit to learning. One of the earlier panelists today spoke of a woman who was remarkably engaged with her life as she was dying. That is an important part of life.

So whether or not we should be reimbursed as third-party, I think we should. I think if I could see a lot of people who have had strokes before they have run out of their medical reimbursements, they would get much more improvement.

I wasn't trying to imply that anybody could do anything, but that we can always learn to do better.

DR. GORDON: Thank you. Thanks for these clarifications.

Yes, Bruce.

DR. NORDSTROM: I think I agree with your comments, in that, wellness, depending on who you are talking to, is very difficult to get your arms around, what does it mean. To that extent, I think we have to be very careful what we say about what our services provide in the way of wellness. So I keep coming back to, and I think it is important, that this commission do everything that it can to promote funding for research so we have good information and good data to say where a therapy can promote wellness, and where it doesn't.

DR. GORDON: Thank you. With that, our time is up for this session. So we will conclude. Thank you very much. Thank all of you for your comments.

We now move, again, into small discussion groups. The discussion group on CAM in Self-Care and Wellness: Nutrition, will be in the breakout room, the room that we had lunch in today. The other workgroup on CAM and Wellness in Special Populations will be in here.

I ask all the groups to finish and be back in here by 5:10. We invite those of you who are here with us to come to either one or the other group and be there to witness what goes on. Then we will be meeting here as a whole at 5:10. When we meet again, I am asking the group leaders and the groups to proceed in the way we did yesterday.

Excuse me, could everybody just pay attention for a sec. If we could bring back some issues, four or five issues, and a couple of recommendations from each group, and then we will present those, and then we will have time for discussion, and we will end for sure by 6:15, and maybe a few minutes earlier. So we will be back in here at 5:10.

[Recessed to reconvene following workgroup meetings.]

DR. GORDON: We have a few members who have gone home already. Thank you for staying, those that are here. So we are going to begin. David and Joe Pizzorno will present the findings of their group, and then we will discuss both groups. Both David and Joe have to go very soon after they do their presentations, so let's get started.

Which one of you guys wants to go first? David, go ahead.

CAM in Self-Care: Special Populations

DR. BRESLER: I also want to thank the members of the audience who were here and provided some excellent suggestions for our group. We really appreciate your input as well.

We looked at special populations regarding wellness, and we identified quite a few more than we took testimony from here. We felt the wellness ought to address, not only the underserved, people in the workplace, the elderly, and people dealing with end-of-life issues, but also minorities. We think wellness ought to be introduced into pediatrics and early childhood development.

We think there are some special issues in the gay community, issues in pregnancy, issues that women have, the teens have, that men have. The physically and mentally challenged have issues with wellness as well. Health care providers have issues around their own wellness, healing the healer and so forth, and the chronically ill, even though they may have chronic illness, there are people that can have a chronic illness and still have a high level of wellness. So we expanded the populations a bit.

We identified some issues that we thought would be helpful to address. No. 1, that special populations tend to have very limited resources. They have limited money and limited ability to take advantage of wellness programs and wellness resources, even if they are there because they tend to cost money and they are not being reimbursed.

We think there is a major issue in terms of access to wellness services. There are people that live in rural communities where they are just not available at all. There tends to be a lack of trained providers in wellness medicine or wellness health care. There are language and cultural issues. There are transportation problems.

Community outreach is another issue that we think needs to be addressed. Access to wellness information, and we have talked a lot about access problems, we think that is an issue that needs to be addressed. Also, an issue of internal barriers and resistance, that inside, people have an internal resistance to wellness for all kinds of reasons. That needs to be addressed as well.

We think other issues revolve around just the general lack of knowledge and information about wellness and wellness resources. Again, related to internal resistance and barriers are people's belief systems about wellness and to what extent, if you have an illness, even if you are one of these special populations, to what extent you can enhance your wellness.

We made several recommendations, and I will just go through them quickly in no particular order. We think that early and continuous education in wellness is essential, not only for providers, but for parents and children, for community and faith-based organizations, for the media, which has a strong influence on our culture, and also for educators, that this information needs to be made available to them.

We think that health care providers need to model wellness, and community leaders as well. In celebrities and community leaders who are spokespersons on various issues, we think they should be spokespersons on wellness, especially to the extent that they encourage self-care.

We think there needs to be increased research on working models of wellness. There are a few out there that have been around for a while and seem to be working well. We need to take a closer look at what they are doing, how they are doing, and what kinds of infrastructure they use, what kinds of outcome measures they look at.

We think that we need to demonstrate the cost effectiveness of wellness programs to employers, even things like having employers give wellness days rather than sick days. There needs to be a change in our culture around the whole issue of what wellness means in the workplace.

We think provider training with community service ought to be offered as a recommendation, so that as we enhance the training of providers, like we do with student loan forgiveness programs. We give people the opportunity to get forgiveness of their loans if they go into underserved areas and bring information. We think is something we could do in wellness as well.

We think there should be increased reimbursement for wellness-oriented services, especially for allied health providers who, at fairly low cost, can bring wellness information into these special populations.

We think we ought to look at the notion that health insurance premiums might be related to the degree to which employees engage in wellness behavior. If your cholesterol is low, if you don't smoke, if you exercise, your blood pressure is low and so forth, maybe there should be reduced premiums, or even a reverse premium, which incentivizes wellness.

We think environments need to be enhanced, and that is a whole area that we think is relevant to wellness.

We think wellness services need to be included in government subsidy programs, Medicare, Medicaid, CHAMPUS, things of that sort. Again, we have talked about the notion of rewards and incentives for wellness.

We want to encourage the media to promote wellness in our culture. I made the comment because I work in Los Angeles and have lots of contact with the media. It is very clear what "Rain Man" did for autism, and it just takes one good movie to bring a lot of these things into our culture. We think that the media should be encouraged to promote wellness and to bring it into our culture.

We want to bring wellness into existing cultural interests to develop simple and available wellness assessment devices. You can go into any pharmacy and get your blood pressure checked for free, anywhere. Wouldn't it be nice if we had a little wellness instrument that could tell people how well they are, and how well they could be, that was as accessible blood pressure devices.

We want to encourage accepting of personal beliefs about wellness. There was some discussion we had about starting where people were at. The notion is not to take too big a bite. We define the right size bite as a bite that is small enough to manage, but big enough to matter. The idea is you start where people are at and you take them up a notch at a time in terms of their wellness behavior, not preach to them and tell them what they should be doing, but take them by the hand and help them move up the wellness scale, step by step.

Finally, there was some discussion about creating a mission statement for the wellness concept, that maybe there is some overriding mission statement that we can come up with that would still be respectful of individual beliefs and ideas, but could generally convey the concept of wellness so that people understand what it is.

Did I fairly well cover it, in terms of our group?

DR. GORDON: Great, David. Thank you. That is terrific, a really wonderful job.

Joe.

DR. PIZZORNO: We had quite a dynamic group, and thank you all for participating.

We identified nine problems and nine recommendations to solve those problems. We also, however, disciplined ourselves and prioritized them to three. So I am going to read to you the nine problems we identified, the three solutions we identified as what we think is the most important, and if we have time, I will mention the also-rans.

Issues, problems: (1) conflicting diet theories; (2) Medicare covers nutritionists for health care problems in only two conditions; (3) inadequate consumer information about what is put into food products; (4) serious underutilization of the existing body of nutrition knowledge that would dramatically decrease the major diseases afflicting society today; (5) excessive consumption of nutrition-poor processed foods; (6) the clinical value of multifactorial nutritional supplements in the treatment of disease and promotion of wellness is not accurately documented; (7) medicinal/functional foods are being widely promoted, but the long-term effects are unknown; (8) the contradictory food pyramids; (9) the excessive consumption of soda and other health-damaging fluids.

DR. GORDON: Excessive consumption of what?

DR. PIZZORNO: Of sodas and other health-damaging fluids, using the example of Arkansas, of a gallon a day, which is mind-boggling.

And the winner is: (1) develop comprehensive programs to educate the public and health care professionals in the use of nutrition to promote health and prevent and treat disease; (2) find ways to make whole foods cheaper and as available as processed foods, and develop ways to facilitate sustainable agriculture; and the third one is, fund demonstration projects of the impact of multifactorial nutritional supplements in the promotion of health and treatment of disease.

Now, the also-rans in terms of recommendations are: Develop a voter pamphlet-like document that gives the pros and cons of each diet type. Make it available on the website, make it available through public health, and make it multilanguage.

Another one which didn't quite make the cut is, expand federal coverage for nutritional counseling and education in schools and for patients.

Another one was, develop comprehensive consumer nutrition education. For example, better nutritional labeling for foods.

Another one that didn't make it is, to fund research to examine the long-term effects of medicinal/functional foods.

The next one which didn't quite make it is, create a new food pyramid -- this is one I really liked

-- which has at its base whole foods, and then goes up to processed foods, then to food additives, et cetera.

So ignore all the various theories, start from whole foods and work from there, and finally, do the same thing, but do it with a liquids pyramid. Put water at the bottom, and at the very top, it would be the soda pops. Thank you.

DR. GORDON: Great. Terrific. Thank you, Joe.

[Applause.]

Panel Discussion

DR. GORDON: So, discussion, beginning in any of these places on the pyramids or circles, or whatever figures there are.

Yes, Don.

DR. WARREN: I like the wellness days off. I like that, and I will implement that when I get back to the office.

DR. BRESLER: We used to call them mental health days, rather than sick days.

DR. WARREN: And you don't give them any time off for sick, then?

DR. BRESLER: We said, why get sick; why not go crazy, you know. So we would give them a mental health day when the pressure would get too high, rather than the sick time off.

DR. WARREN: Cool.

DR. CHOW: The Center for Improvement of Human Functioning in Wichita, Kansas is a huge institute, and Dr. Hugh Reardon is the head of it. They have instituted wellness days, and they don't give sick days. When they go to the hospital, they don't send them flowers or anything. They wait until they go home, and then send them flowers when they get better. And so, they do take wellness days.

DR. GORDON: I have a question. Was there any feeling about priorities in the first group, in David's group? Or, was it really just sort of, "Okay, here it all is and let's see where we go from here?" I just wanted to check in.

David?

DR. BRESLER: Yes.

DR. GORDON: Was there any feeling about priorities for any of those? Or, was this really, "This is the list and let's just sit with it and see where we go?"

DR. BRESLER: Pretty much. It was really more of our recommendations to the staff, to let the staff work with that material.

DR. GORDON: Okay, that's fine.

In the food group, so to speak, how did you arrive at the specifics, sort of, the top of the hit parade?

DR. WARREN: How did we arrive at the top of our hit parade?

DR. GORDON: Yes.

DR. WARREN: We voted on it. We took the nine categories that we had, and everyone was allowed to vote as many times as they wanted to, only once per item, though, and the top three items were what we came up with.

DR. GORDON: Okay, great.

Wayne, go ahead.

DR. JONAS: I just wanted to say, I need to change my vote because I am getting arm-twisted over here.

[Laughter.]

SISTER KERR: And well he should.

What do you all think about a cooking pyramid? I brought that up. I put microwave on the bottom.

DR. GORDON: I love the idea of those different kinds of pyramids. I think that really could be fun. I think it is really interesting idea because it might catch people's imagination.

DR. WARREN: I like that. I liked the food preparation pyramid, but we had to limit it to three, but we didn't put that down as one of our nine, either, did we?

DR. JONAS: It has four sides.

DR. WARREN: Yes. Wayne came up with a four-sided true pyramid instead of just a triangle.

DR. JONAS: Three-dimensional.

DR. WARREN: Three-dimensional, okay.

DR. GORDON: I just want to ask a couple questions. How far did you get with the comprehensive education program? Were there any specifics to that? BY whom and in what context?

DR. JONAS: Well, I think the issue around which that revolved was what I think we heard today, the dramatic evidence that already exists that if we were to substantially alter diet, and that would require some behavioral interventions, obviously, but of the known risk factors, that that would markedly reduce many chronic illnesses, and a few of them were mentioned.

Our feeling was that we should do this on multiple levels, not just federal government, but private sector, and it should start from elementary school and go all the way up through graduate education, including health care education, and that there should be media and various other types of activities to try to communicate and facilitate behavioral change toward those types of changes that we already know could make such a large impact.

DR. GORDON: Great. It sounds terrific, really.

DR. JONAS: Oh, yes, preeducation, breastfeeding.

DR. WARREN: Yes. We even went to breastfeeding. For 13 years, I examined school districts in five counties, K through 6, and I talked about nutrition, about eating right, about forgetting the chocolate milk, and all this stuff, and in those 13 years, the decay level and the disease level in those children went down.

Then I finally got too old, and gave up the ghost for it, and suddenly, now they are back to rampant decay and gross disease again, and they are back to allowing them to drink the Cokes and the chocolate milk and stuff in schools. So it works.

DR. GORDON: A question for both groups. Are there people you would like to see here? Is there information you would like to have, either at the Commission meetings or in written form from agencies, from individuals, from organizations that you think would help us shape some of these recommendations more?

SISTER KERR: I would like to see CDC speak to us.

DR. GORDON: Speak to which issues? All the wellness issues?

MS. LARSON: Well, no. Somebody mentioned today there are new epidemiological approaches. It would be interesting to see what they are looking at with nutrition. I mean, hey, we are back to the whole issue again of the epidemic of obesity.

DR. WARREN: I would like to see somebody with Price-Pottenger talk about wellness and nutrition, based on Weston Price's work on nutrition and degeneration.

DR. GORDON: Jeff Bland actually does a real nice talk about that, about Price-Pottenger, studies on different populations and eating habits, and the effect on the shape of the jaw and some other parameters.

From either committee, other kinds of information? One thing that comes to my mind is, if we are thinking about a recommendation about making whole foods cheaper, we need some input from either organic farmers, Department of Agriculture.

DR. WARREN: One of them is a newspaper monthly called "Acres USA." It advocates organic sustainable farming. I think that would be good, to get somebody from their organization to come in and talk to us.

DR. GORDON: Yes. Go ahead.

AUDIENCE PARTICIPANT: Can I recommend Gary Nall come in and speak?

DR. GORDON: We can certainly get in touch with him. The most important thing at this point is people who can give us ways to implement the recommendations, and that is what I am feeling.

So, for example, part of our job in these next few months, particularly Steve and my job, is to go and talk with some of the agencies where the recommendations are going to affect them most, and get them to take a look at what we are doing and to get as much of a buy-in as we can.

So I think one of the places that we are being guided here is the Department of Agriculture, and see who our allies are there, and who can forward the mission.

Go ahead, Wayne.

DR. JONAS: One of the things we discussed, also, was demonstration projects. Obviously, as we have talked about many times, but also came up here, is that a lot of the data on wellness and health promotion and prevention comes from epidemiological data or comes from observational studies. And so, to support a number of demonstration projects, examining the safety effectiveness, not efficacy but effectiveness, as well as the feasibility of implementing comprehensive wellness programs in different populations was something that we discussed.

To do that, obviously you would have to have the agency that would be involved in supporting or somehow facilitating that type of a project. A number of those have already shared with the Commission.

DR. GORDON: So, who do you see, and anybody else as well, but you know the terrain pretty well, what federal agencies do you see as being obvious players in this arena?

DR. JONAS: Well, in terms of public health, the CDC is obviously one that does facilitate and does research, and have the methods down already to do these kinds of observational trials, but there are a number of groups that have the populations, special populations, and resources to do that, and we heard from those. The VA, for example, was one of those, perhaps the military.

Those are the ones that come to mind right now, but we could sit down and actually think about that, and go back through some of the other testimony in which that was brought up, because, actually, it was brought up several times in our discussion, and several of the folks from federal groups said, "Yes, this is something we would like to do."

DR. GORDON: Great.

Charlotte, go ahead.

DR. JONAS: NIH also does similar types of things.

SISTER KERR: Thanks, Wayne.

Remember when we got off a little bit into Fortune 500, and I was saying I thought these people might want to be involved, there are a lot of great people. Today, when we got into food and nutrition, I started feeling a little cranky about petro-chemical people. I thought, I wonder, still, if we need to hear from these people.

Part of our commitment is to be "we," and not "them" and "us." Kelloggs, even, was started by the famous Kellogg Sanatorium. I just wonder if there aren't some big businesses that we should be hearing from to build partnership. It seems like there must be some way for there to be a win-win, rather than the microwave people hating us if we put out a pyramid that knocks them. Maybe we need to be learning some things as well.

So it is just a thought, and some other people might have an insight.

DR. GORDON: Steve, go ahead.

DR. GROFT: We do have something scheduled for the next meeting between reimbursement, access, and research.

DR. GORDON: I think what we can do is raise some of the questions about wellness with them when we send out questions to them. I think that would be a real good idea. Thank you, Charlotte.

DR. GROFT: The next meeting is going to focus on reimbursement for the first day and a half. Then the second day and a half will focus on research too, and a little bit of access and delivery, not a lot, but just to clean up what we didn't get to last fall.

DR. GORDON: So one of the things that we need to do, and this would really be both a staff function, but also the subcommittees that are going to be working on these two sessions, is to help formulate questions that will address some of the issues that were raised today that we might not have had in there, today and yesterday, in terms of information and in terms of wellness.

That is what I was talking about earlier, in terms of discussing research issues related to wellness and how we do it and where we do it.

Anything else?

[No response.]

DR. GORDON: Okay. This is great. Did everybody enjoy these two days?

PARTICIPANTS: Yes.

DR. GORDON: So thank you. Corinne did a fabulous job as the lead person on these two days.

[Applause.]

DR. GORDON: As usual, everybody else was in there pitching.

DR. CHOW: And we want to thank the Chairman, who did a great job.

DR. GORDON: Oh, thank you.

[Applause.]

DR. GORDON: Thank you all. We will see you in May, and we hope to hear from you anytime before then. Thanks a lot.

[At 5:40 p.m., the meeting was adjourned.]

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