but to ask for a middle ground, a description of something that will allow us, it is not a drug, it is not a food, et cetera, but then would allow some protection for the primary purpose of incentivizing the production of these products in a reasonable, scientifically-based, quality way, it would be a proactive statement that we could make and that the federal government could be involved in.

MS. CHANG: We have about 10 minutes left, Tieraona.

DR. LOW DOG: Okay. David.

DR. BRESLER: I think there are other precedents also in ways that the government has stimulated or incentivized the private sector to do research, particularly through tax credits or low interest loans.

I think somebody does have to do the basic research on just plain echinacea. You know, we need to know that. I think that we can take a strong stand on recommending more creative ways to incentivize the private sector to do the research that is needed.

Look how the private sector has carried forth

pharmaceutical research, for example, and again, if tax credits or low-interest loans, I mean I think given the climate, these things would be very attractive to the private sector right now, and this is definitely something the government can do to stimulate research in things it is interested in.

DR. LOW DOG: Some of this was addressed under Issue 4 on page 11 in your briefing book, but again, reading through some of this I think would be helpful.

One of the recommendations was also about package inserts, that one of the issues to the public is because of the nature of structure/function claims, it leads the average consumer sometimes feeling a little bit at a loss to really know what these substances are really for, or if there is people that shouldn't be particularly using them, if there is cases where there may be interactions with particular drugs.

One of the recommendations that was listed under Issue 4, that I would just like some comment on, was about package inserts that may also include who shouldn't take it, or there might be a potential drug interaction with, or if you shouldn't take it if you have

high blood pressure, and more information about the product. That is a recommendation that was put forth here. Any comments on that?

Again, if we are looking at maximizing the benefit of CAM to the public, one of the things is take a look at what consumers often complain about is that they are not quite sure what some of these are actually meant to do because sometimes a structure/function claim can be kind of vague.

Should we make any more recommendations for package inserts, and are we concerned, are there any public safety issues we should be thinking about here?

DR. WARREN: You are dealing with over-the-counter stuff, though, with this. The practitioner is supposed to know the interactions.

DR. LOW DOG: Many people just self-medicate, though, Don, so they just go to the store, and they just buy on their own, they are not seeking a primary care or a naturopath or acupuncture, they are just buying off the shelf.

DR. FINS: There is a paradox here. In trying to not give extra credence to a supplement, the labeling

was such that it didn't give the consumer enough information, and we need to really I think rectify that with clarity in labeling and maybe having some sort of board, you know, professional lay board to sort of assess the level at which these things are written just to protect people.

I think the Bob Blendon article that was circulated suggests that the overwhelming number of Americans want more regulation in this area. What form it takes, I think is a complicated one, and the use of supplements is going down because of all the recent publicity about some of the adverse events, so I think people need information, and I think the labeling has to be accessible in a way that people can understand it, because we get claims that are kind of confusing because they were intending not to be definitive.

DR. LOW DOG: Tom.

MR. CHAPPELL: The guidelines that we adopted earlier this morning in terms of coming up with evidence-based results, outcomes, you know, if we use that same language for looking at herbs and their effect on the body, we would be able to go beyond DSHEA and we would

not have to go the full route of the NDA. That is what I am talking about for middle ground.

It doesn't cost a lot of money to decide that you want to find out if an herb does a specific solution. It just needs objective goals and scientific methods and testing, and then trials. It really doesn't take an NDA to establish that. This is my concern.

DR. LOW DOG: You raise an interesting issue about methods and testing. That has also been raised, is that it is very difficult. At this point, there are not established and validated methods for many of these supplements, so testing is difficult because a manufacturer may be using a different method than the laboratory that tests it, and this has been one of the problems with looking at natural products is that at this point, many of them don't have a validated method.

I think we will hear more about that later, but I think that there may want to be some language in there about just supporting that as basic science and also organizations that are working on that, that we would like to support those endeavors.

Any comment on that? Jim.

DR. GORDON: I would just like to get a sense, if we do have some kind of consensus, on this issue about providing information before we move on to another topic, because I think it is a really, really important one, it is one that we mention in the Interim Report, and one that I think we may need to lay out in considerably more detail for the Final Report.

So, I would just like to ask people if there is a consensus that we, as a commission, feel that somehow information, whatever the state of the art of information is about the different products, needs to be available to the people who are using the products.

DR. LOW DOG: Ming?

DR. TIAN: I think the label, we all know the label law by FDA. I think the problem is how do we deliver the information to the public, as well as the medical profession, because this label law does block the people to know. As manufacturer, you can't tell patients or tell the public that it works for arthritis or that it works for osteoporosis. How do we do that, because this is for American people, to maximize the best benefits, but however, if we don't change it, if we don't give the

manufacturer or company or doctors the right to share the information, how do we do that?

DR. LOW DOG: Joe.

DR. FINS: Maybe we want to distinguish between the claim and the side effects, so like you can't make a claim about ginkgo biloba, but you might want to say if you are on warfarin or Coumadin, you shouldn't take this drug because it also can further thin your blood, so maybe it is on the adverse side that we want to get more specific, and not on the claim side, which is as yet unproven.

DR. GORDON: My feeling is I would like to give people somehow the evidence that is there, whatever it is. If there is no evidence, there is no evidence, and that is fine to say. If there is evidence to somehow present it, I just feel on all sides of the question, what the benefits, what the disadvantages, what the side effects, what the interactions are.

DR. LOW DOG: Any other comment? Joe.

DR. PIZZORNO: I feel very strongly the public needs to be educated on how to use these things properly, and I have major doubts about whether we can do it on a

label. I think that this is an issue that has come up again and again. We need to provide multiple pathways for access for the public of what is most current, and while the label has to have some information, maybe the best thing the label could do is simply provide a web site address and/or other resources people can go to, to find out more about it.

DR. LOW DOG: Tom.

MR. CHAPPELL: There are over 100,000 deaths each year for drug interaction, drug with drug, synthetic with synthetic, so we need to recognize the context within which we are talking about interaction with herbs and herbs with drugs.

I think in order to have a goal to provide more information, Jim, we have got to break this task down into some manageable phases, short term, long term, because this whole business of herbalism will just give you a breakdown mentally and financially and everywhere, and until you begin to chunk it down, you can't make it into manageable, so I think part of our recommendation should be to recommend some first stage, second stage, short term, long term, you know, the first 15, the next

10 or whatever are the most popular, but we are going to have to approach it this way because it is unmanageable.

DR. LOW DOG: A lot of scope. Jim had asked for consensus a little while ago about adverse events and sort of providing information, and I think it was also about benefit, as well, but under Issue 5, on page 12, it just makes a few recommendations, one, about warnings about potential interactions, warnings for pediatric use or pregnant women, nursing women, where that information might be known.

Again, I just want to know if there is consensus on that where it is known, and let's just be real honest, that we haven't begun to understand where the potential interactions are, and this will be somewhat hard to do. Much of it will be theoretical.

When I read this, while I am very much in favor of it, where it is known, it is going to be also a difficult task because much of this is theoretical information at this point, where there are potential problems.

George.

MR. DeVRIES: I am in favor of it in general,

but what I would say as a caveat is I know that, you know, Micromedics has a drug-herb interaction guide on St. John's wort alone, there is 86 known interactions. So, the amount of disclosure is pretty significant, just in the context of there will be a lot of information here which may be overwhelming for some consumers.

DR. LOW DOG: And wouldn't fit on a label.

MR. DeVRIES: You are definitely not talking a label, you are definitely talking insert. I mean there is no way to fit the amount of information I have seen on that interaction guide for St. John's wort is pages and pages and pages.

DR. GORDON: What we are talking about right now is both a general principle and then what everybody is raising is the complexity of the issue. If we are agreed on the general principle, we can start wrestling with some of the complexity at the October meeting and try to get some information between now and October about different alternatives, different ways to do this.

DR. LOW DOG: Effie.

MS. CHANG: I'm sorry, excuse me. I just want to let you all know we are out of time for this session.

DR. LOW DOG: We will just have these last two comments.

DR. CHOW: I agree with a lot of things that are said. One thing I caution is that I think Tom, it is, and Bill brought out the traditional system of medicine has a lot of reactions and numbers, and so forth, and I think we need to look at the safety for the people, but I don't think we need to alarm people. We need to put it in perspective that, yes, we are cautionary about this, but make some statement in comparison with what Western medicine is, you know, the amount of side effects versus the drug effects, the supplement effects, so it puts it into perspective. Otherwise, people read this recommendation of making all these adverse reactions.

I definitely feel that we need to put some positive things in there along with the adversities, not just emphasize the adversities, and do have this comparative kind of knowledge somewhere, not on a label, but somewhere, web site, et cetera.

DR. LOW DOG: Tom.

MR. CHAPPELL: As we have discussed, oversight

of composition, quality, safety of botanicals is doable. There are experts in this country, like yourself, who know what the adverse effects are for a large number of herbs. It is very well documented in many, many files.

My interest here would be to see us convene a review board of those experts, so that this review board gives credence to a particular herb. Now, if that review board were either CAM office or industry, then, you can maintain flexibility and continuity. If, however, that review board is within the FDA, then, you have stopped all the progress of product development.

It has to go inside a regulatory agency over which you have no control for time and priorities, and so forth, and I am very concerned about subjecting product development progress for consumers, bringing health in this area in a system that gets bogged down within the FDA. So, I would rather see this recommendation be handled outside the FDA.

DR. LOW DOG: On Issue No. 6, on page 12, actually, it was recommended, and this recommendation within the FDA, but it was again sort of an Office of Botanical Products, so that you had people with expertise

in this area, that have more expertise in handling it, so it doesn't get bogged down.

Jim, would you like to summarize for us?

Session Summary

DR. GORDON: Yes. The first part of the discussion had to do with facilitating research, and there was a general agreement that encouraging partnership between CAM and conventional researchers was one way to go and an important way to develop research.

Secondly, it was understood that both technical assistance and money would be necessary to help people in the field to begin research in a number of these areas.

Next, it was understood that those people who are going to be doing research in areas that were at this point unconventional, might well need an umbrella of protection as they are doing the research, and that that umbrella of protection would be protection both for the researchers, and, of course, for the people on whom they were doing research.

This is an area of general agreement. I don't think we have really begun to, or we just began to wrestle with the particulars of this area. It is pretty

complex, but there was a general sense that we ought to encourage and protect people as they are doing research and, at the same time, we needed to ensure that there was safety and that all those who were involved in the research were protected by people who had a deep knowledge of the conditions that were being treated, that they were involved in the research, as well.

DR. FINS: The contingency element.

DR. GORDON: Yes, that their participation in the research, and I think we used Nick Gonzalez as one example of a kind of developed phase of this where this is participation of both an institution, academic medical institution, and adventurous private researcher, and government funding, but there was also the recognition that at earlier stages, there may need to be something like field studies, which has been very much a part of the agenda for the OAM and NCCAM from the beginning, where people in the field are helped to do the research, protected while they do it, while the subjects, as well, are being protected, and that ethical standards would need to be established.

I am a little vague on this because I think we

are still vague, and this is clearly an area we need to address more.

We then turned our attention to issues related to products rather than research procedures, and there was a general agreement that DSHEA needs to be implemented and that we need to make at some point recommendations that whatever funding for the FDA be directed clearly at the implementation of DSHEA, that there be a clear connection between any recommendations we make for funding and that that funding be used for DSHEA.

In thinking about implementation of DSHEA, it was agreed that we all ought to have a look at the Office of the Inspector General report and that we also need more information about European models of reporting and notifying, and have someone who is working with the office now, who is doing a special project on what is happening internationally, and we can ask her to help us gather some of this information and have that available for everybody.

It is clear in thinking about issues like adverse events and interactions that we understand that

although these are extremely important areas, that they are obviously areas that are not just confined to CAM approaches, and that was pointed out by several people, and that whatever discussion we have about that, this is just understood as a public health issue across the board.

One of the other issues on which there was substantial agreement, and I think this addresses the last question that was raised, is that there has to be participation of CAM professionals and experts in all issues related to the development of supplements, of herbals, and all issues related to adverse events reporting, that this is not something that can be done by people who are purely outside the field, and I think this is a general recommendation that we were making in a number of different areas.

Another issue that was raised, and I felt there was consensus on, is that we need to begin to look toward finding a middle ground between DSHEA and New Drug Applications, that perhaps there is a special area for botanicals and other traditionally used substances, and that we may well be working toward making some

recommendations about what that middle ground will look like.

It is also clear that in the area of information, that the board, how that is going to fall out, whether that is inside the FDA, outside the FDA, I don't feel like we have a consensus on. That is clearly an area which we need more discussion about.

We understand the need for a middle ground, we don't know exactly where that middle ground is going to lie. We understand the need for CAM professionals to be involved in establishing that middle ground.

Also, it is clear that much more information is needed -- and I am sure we will come back to this somewhat in the sessions on public information -- but in this area of products related to regulation of products, that there needs to be a great deal more information available, and clear that there need to be many ways of providing that information, that the label is not going to be the way to provide this complex information.

Again this is an area that it is pretty clear we have to deal with much more as we move along, how that information is going to be provided, we don't have

specific recommendations for.

That is my summary of what we have been doing this last hour or so.

Anything else?

DR. FINS: Just one thing. If, in fact, some of these recommendations are taken in, that there is some sort of sunset clause where we would then have feedback to an oversight committee to evaluate and look at new legislative paradigms.

DR. GORDON: Thank you, Joe.

DR. LOW DOG: Good job.

DR. GORDON: Thank you, Tieraona.

We will come back promptly at 1:30 and then we will have an hour and 45 minutes for the next discussion. So, thank you, everybody. Have a good lunch.

MS. CHANG: Just to let the public know, we will be vacating this room during our lunch break, and the doors will be locked, so make sure you take your things with you, and we will open up around 1:20 or so.

[Lunch recess taken at 12:35 p.m.]

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

[1:40 p.m.]

DR. GORDON: We are going to begin now and we are going to be talking about Education, Training, Credentialing and Licensing.

It's the Joe-II's or the two Joes. Joe Pizzorno will be leading the discussion, and Joe Kaczmarczyk will be working with him.

Discussion Session II: Education, Training, Credentialing and Licensing

Part 1: Education and Training

DR. PIZZORNO: I thought our conversation at lunch was interesting. Actually, it coincides quite well with how I want to run this session. I would like to actually start our first part of the conversation with a discussion of our process.

In general, I think we should have a fairly focused and defined way of going about this, so that we arrive at the conclusions and the recommendations that we are looking for.

I am going to direct us in a three-step process. Step No. 1 is to clearly understand the

questions that we are being asked to address. I will spend a few minutes on an overview of what I think those to be.

Step No. 2 -- and I think this is important -- is that we answer the question what are the characteristics of a good recommendation. I think that is a scenario that we have been having some challenges with. I want us to be real clear about when we see a good recommendation, how do we know it.

Step No. 3 will then be to look at the recommendations and come as close to a consensus as we can on those recommendations.

So, I will be using the same process both for the educational component of it, as well as the licensing component of it.

Are there any questions about that before we start?

[No response.]

DR. PIZZORNO: So, let's start with the Education and Training. You all have on your desks this handout that Joe K. put together addressing the various issues.

When I look at these, I see two key themes, you might say, that come through, both the recommendations as summarized by the staff, and also in looking at the documentation we have received in the full booklet. Also, I would like to take this opportunity to congratulate the staff for I think some excellent organizational material that they have provided for us.

So, the two issues I see are, number one, level the playing field both in terms of resources, as well as accountability. The second I see is a strong emphasis on cross-training, that is, training of CAM professionals in conventional medicine, as well as conventional medicine in understanding what CAM is about, as well as training together.

There is an adage in medical education that I think is very appropriate here, and that is practitioners who train together practice together, and I think the more cross-training we can do, the better.

So, given those as kind of the themes, and we are starting out looking at the recommendations, as summarized here by Joe Kaczmarczyk, what are the characteristics of a good recommendation? What should

that recommendation look like for us to know that this is something we want to pass on to the President and Congress?

As people talk about this, I will be taking notes, so please excuse me. Linnea, do you have something to say?

MS. LARSON: Thank you. I have four criteria. The first is clear and jargon-free. The second is non-global and of achievable scope.

DR. PIZZORNO: Please slow down just a little bit. The first one was clear?

MS. LARSON: And jargon-free.

The second is non-global and of achievable scope.

DR. PIZZORNO: Could you explain that more, what you mean by that?

MS. LARSON: You don't lump everything together. It is a point, a troublesome point for me is the use of a term called "CAM community," that is a global. We need to be more specific.

The third, for me, was operationalizable meaning who does what, when, and how to effectuate the

recommendation.

The last was evaluable, how would you know if a recommendation was followed.

DR. PIZZORNO: I think those are excellent recommendations. Also, another statement on process. My preference would be for people to present what they think are good recommendations first, get them all on the table, and then once we hear what everybody think are good recommendations, then, we will go back and start discussing them and evaluating them. It is okay to ask the person who made a recommendation what they meant by that.

Tieraona.

DR. LOW DOG: I guess Linnea raises the point about CAM community and also then coming to the language of a basic CAM curriculum. What is that? You go to a medical school and you say we want a basic CAM curriculum. What is that, what are you defining as CAM?

Some of the statistics that we are quoting in some of this paper is, you know, 1 in 3 Americans, 42 percent, and yet when you look at what that covered, that meant everybody that was taking a multivitamin, people

going to Weight Watchers, people going to Alcoholics Anonymous.

We are quoting those statistics as CAM, as people utilizing it, but I don't think that is what this group intends is Weight Watchers as CAM curriculum or as part of the CAM community. So, I think again, we are going to have to define what exactly we are talking about because it is a very large and diverse group, and I think that was part of Linnea's point, was about the community, and it speaks right to the heart of this, the need for basic CAM curriculum, what exactly are you asking the medical schools to do.

I am not asking for specifics here. I am just saying that it is fundamental, someplace we are going to have to address that, because we keep throwing it out everywhere, and that would be my first question is what is it.

DR. PIZZORNO: Other comments about what would be an identification of a good recommendation?

[No response.]

DR. PIZZORNO: Okay. Well, I will prime the pump here a little bit.

How about something like educational standards consistent with the skill base that is expected?

DR. GORDON: I don't know quite what that means.

DR. PIZZORNO: It is very clear to me. How do I say it differently? If a CAM educational program is purported to develop a certain level of skill in a modality, therapy, diagnostic procedure, whatever, then, the curriculum must be consistent with demonstrating that that skill has been actually created in that individual receiving that training.

DR. GORDON: Joe, I'm sorry, what does that have to do with good recommendation?

DR. PIZZORNO: Maybe that is a recommendation.

DR. LOW DOG: That's a recommendation.

DR. PIZZORNO: That's the recommendation, yes.

DR. GORDON: Maybe we need a little more clarification. Do we agree that these, what Linnea has said, that these are the qualities a good recommendation should have, because you have kind of got us down that road a little ways, and I feel like we may need to finish up that piece of the journey.

DR. PIZZORNO: Yes, I want to finish that piece of the journey first. What does a good recommendation look like?

DR. LOW DOG: Could I just ask for clarification? I thought at lunch we had said we were going to do this tomorrow at lunchtime?

DR. PIZZORNO: Jim asked us to do it now.

DR. LOW DOG: Fine, fine, fine.

DR. PIZZORNO: I had already planned this out, so I thought it was good it came up at lunch.

DR. LOW DOG: Very good, Joe, okay.

DR. PIZZORNO: Also, you could also look at the recommendations generically, which I think that Linnea did. We also can look at recommendations particularly to the area of education, what do good recommendations look like in the area of education.

So, a recommendation in the area of education, what are some other characteristics that would be indicated it's a good recommendation, or are we ready to discuss what we have now?

MR. CHAPPELL: A recommendation that honors both our historical approach, as well as our new ideas

for CAM, so it honors both Western and CAM modalities, that the outcomes contribute to that.

DR. GORDON: Related to that, I would add that a good recommendation is one that is based on some experience that is trustworthy and enlightening. So, for example, a good recommendation in the field of education might be based on one or more model programs that we have heard testimony about or participating in, so that we have a basis on which to make the recommendation, that it is not simply a theoretical recommendation.

DR. PIZZORNO: Effie?

DR. CHOW: I don't know whether this answers any question, but I think in a good recommendation, I agree with Linnea, we need a good objective, but to get a good objective, we have to be clear about the definition of what we are talking about.

It goes back again to definition. CAM, we don't have a definition of CAM. You know, we have been working on it, but how can you recommend a CAM curricula if we don't know what CAM is, whether on a global scale or a detailed scale. So, I go back to that.

First, you have to define what it is you are

requesting for CAM curricula, so define that, and objective methodology and outcome and evaluation. That's a proposal, you know, a recommendation.

I believe again that we have to have a global view in order to talk about the specifics.

DR. PIZZORNO: Thank you. Any other recommendations about how to characterize a good recommendation?

[No response.]

DR. PIZZORNO: Let me just read what I have got here and let's give people a chance to chat about it because I think we have a consistency here, one being clear and jargon-free. I am going to kind of go through and read these things. If anybody has a problem with it or wants to ask a question or change it, raise your hand.

So, clear and jargon-free. I am going to split this into two. The non-global and achievable in scope. I am going to make this just achievable in scope because I want to do the non-global more thoroughly under defining what CAM is.

No. 2. Achievable in scope. Okay with that? Okay.

No. 3. Operationalizable, who does what, when, and how. By the way, my spelling checker says that is not a word, but I guess we will live with it.

MS. LARSON: I was typing fast.

DR. PIZZORNO: Are you okay with that? Okay.

No. 4. Evaluable, and that is also being kicked out by Microsoft spelling, how would you know if the recommendation was followed.

No. 5. Non-global meaning define CAM. It is not a homogeneous community and standards need to be appropriately defined according to the practice.

Are you okay with this? Okay.

No. 6. Honors historic approach, as well as new ideas for CAM.

MR. CHAPPELL: That was historic approach of Western Medicine, as well as new ideas for CAM.

DR. PIZZORNO: Say that again. I didn't quite follow you.

MR. CHAPPELL: A good recommendation will lead to an honoring of both Western Medicine and CAM modalities.

DR. PIZZORNO: How about if we say it this way

- honors historic CAM and conventional approaches, as well as new ideas for CAM? Does that state what you are saying?

MR. CHAPPELL: Sure.

DR. PIZZORNO: Okay.

No. 7. Based on some experience that is trustworthy and enlightening.

Are we okay? Okay.

So, let's keep these characteristics of a good recommendation in mind now as we go through and look at these recommendations. I think Joe Kaczmarczyk has done a nice job of summarizing these in this handout that you have, so let's go through this.

What I would like to do is we have basically three recommendations. Let's look at each of these and ask if you are okay with it or how you might want to modify them.

So, we are looking at now page 3. We are looking at the worksheet, not at the Interim Report.

So, basically, undergraduate, graduate, and continuing education in CAM curricula. Basically, what we are saying here is we are looking at curriculum which

is both in conventional education, both undergraduate and postgraduate and continuing education, as well as in CAM education, undergraduate, graduate, and postgraduate, ensuring that there is cross-training in each of those areas as appropriate for the practice.

Any comments or additions to these?

DR. WARREN: How many years do we add to the average training to accomplish this goal, or what do we have to supplant in the curriculum as it is right now to put any courses in CAM into their curriculum?

DR. ORNISH: I suggest that might be a good topic for October. What are some general guidelines, the details of how they are implemented, we can defer it for now?

DR. PIZZORNO: I think that is very astute. We are looking at general guidelines at this point, not specific details. We don't have time to do a lot of detail, I agree.

DR. ORNISH: Not that it is not important, just that we don't have time for it now.

DR. PIZZORNO: I'm sorry I cut you off. I think we have agreement that there should be some

familiarization with CAM and conventional medical school education.

Do we have agreement with that basic concept or are you not agreeing with that?

DR. WARREN: I am okay with that.

DR. PIZZORNO: I think everybody pretty much agrees with that.

Bill.

DR. FAIR: I don't understand what you mean by "undergraduate." Now, if someone is taking political science as an undergraduate, once you go to medical school --

DR. PIZZORNO: Pre-M.D. is all we are saying. In medical school, but before they graduate with their M.D. degree is what we are talking about.

DR. FINS: Undergraduate medical education and postgraduate pre-residency.

MR. DeVRIES: But as an undergraduate applying to medical school, you could major in a variety of things.

DR. PIZZORNO: Let's be clear about the language. By "undergraduate," we mean when they are in

medical school, but before they get their M.D. degree.

George.

DR. BERNIER: Would this be mandated to have the educational program, to have a common one, say, across the country?

DR. PIZZORNO: Jim, I am going to leave that to you to mention.

DR. GORDON: I think that is a subject for considerable discussion. I feel like the consensus we have come to is that there should be a program. Whether it should be the same program for everybody and whether it should be mandated, I don't know if we have a consensus on either of those yet.

DR. FINS: I actually chaired the subcommittee that looked into this issue, and we explicitly did not come to an agreement on a mandate, it was a recommendation, and if you go back and look at the minutes -- Gerri, am I right on that?

MS. POLLEN: Yes.

DR. FINS: Yes, because I think we had trouble with groups like the AAMC, and we would have problems with academic freedom.

DR. GORDON: My feeling about this one is that this is one we really need to spend some time on exactly where we want to come out, having heard that report of that committee. When we come back in October, we need to feel we want to be on that as a whole commission.

But the other point, I don't want to lose that Joe made, are we agreed that we are recommending that there be a CAM curriculum for undergraduates in conventional health care education? Okay.

DR. PIZZORNO: Tieraona, you had your hand up.

DR. LOW DOG: Yes, and if this isn't appropriate, just tell me so. I guess part of the thing is from research to education, are we going to make any statement about at what point is there enough research that it shouldn't be seen as CAM, and that is just part of medical education?

I guess one of the worries for me has always been a philosophical one, that if it is always CAM, so it is a separate Thursday class and it is on CAM, it is sort of always the stepchild, it is kind of always out there and separate, but not equal. In some cases, I think that is absolutely appropriate because there is not the

research yet that should make that standard in a medical school, but are we at any point going to just say something about, I mean at what point is there enough evidence, 32 randomized, controlled trials, peer-reviewed journals, I mean at what point does it leave being CAM and just be part of medicine that should be just taught in the curriculum, because if we are talking about level playing fields, it seems in some cases if we continue to look at it as CAM, it is always going to be over there, and you are never going to learn about it, and it is always going to be something less than conventional medicine.

DR. PIZZORNO: Linnea, go for it.

MS. LARSON: It was just a sidebar. That is supposed to be answered tomorrow.

DR. ORNISH: In a way, Tieraona, what you have raised is the same point that Marcia Angell was making, which is, you know, we don't even need to call anything CAM, either it is scientifically proven or it isn't. So, if we really follow that argument to its logical conclusion, we don't need to do anything. We just say, well, just treat CAM the way we treat everything else,

and if it has got science, fine, if it doesn't, fine, and there should be no distinction, but I don't think that is what you are saying, is it?

DR. LOW DOG: No.

DR. ORNISH: So, how is that different?

DR. LOW DOG: Let me just pick something like glucosamine because it's easy. At what point is there enough research that shows that glucosamine may modify the progression of osteoarthritis, and it shouldn't be CAM. It should just be in your rheumatology lectures and pharmacology. You just learn about glucosamine right next to the NSAIDs.

Why does that have to always be CAM, and are we going to address that? Maybe we are not, and I am okay with that, too. I am just saying that at some point, if it is always seen as CAM, it will never be integrated into any sort of curriculum, and I think that some of these things deserve to be integrated.

DR. ORNISH: But what you are saying, Tieraona, is that as long as it is unproven, it's CAM, and once it's proven, it is no longer CAM, but you don't really mean that either, I don't think, but that is really

logically what you are saying.

DR. LOW DOG: No, I am saying that it is because we still define CAM as this -- to me, we have never really resolved the issue of what is CAM and the CAM community, so that has still never been resolved in my mind, and glucosamine, to me, the way it is used and prescribed does not fit into a traditional alternative philosophical model. It is used specifically as a mediating agent in osteoarthritis, so it doesn't fit within a system, but it is lumped under CAM, because it is a CAM approach.

What I am saying is those lines become very blurry to me, and I am concerned that always if some of these things are always seen as CAM, that there is going to be a general perspective that it is always somehow less than.

DR. ORNISH: I get the point, but I am just saying again you still haven't addressed my issue, which is that if you followed your argument logically, then, as long as it is unproven, it's CAM, but once it is proven, like glucosamine, you know, it has got enough history, the randomized trials that show it is effective, so then

it is no longer CAM, it is just standard medicine as though CAM isn't standard medicine or only things that are unproven are CAM.

I think it is a central issue because it has been raised in one form or another by a number of different people, and I think we need to get some clarity, at least in a philosophical sense, because this is going to be something that people are going to be criticizing our report, Interim or Final Report, about, and they are going to say, well, what do you mean, I mean because there are a number of people who say you don't need a National Center for Complementary and Alternative Medicine at NIH. If it has got good science, it will be funded.

Well, it hasn't been until now, and the reason was because it isn't a level playing field, or you will have the journal editors will say we don't need to call it CAM or not, if it has got good science, we will publish it, except that you have something like The New England Journal, who has never published any articles on CAM even though they will say, oh, yeah, we are just waiting for a good article to come along.

So, that is the real issue that we have to address here.

DR. PIZZORNO: Thank you. This is an excellent discussion, and I think you both raised key points. I would like to summarize them, unfortunately, I can't type them while I am talking, and that is, I think, Tieraona, you bring up, too, I thing a crystal-clear point that if we define CAM as modalities, then, we have really lost the whole conversation. I think what Dean has said is consistent with that, too.

CAM is about systems of healing, and within those systems of healing, we have both a philosophical precept, as well as therapies that are used, and research can be done within those systems of healing that document whether those therapies are efficacious or not, and they still belong within those systems of healing.

Simply defining that once something has been proven, it therefore now goes into conventional medicine and no longer is CAM, is not a pathway I think we want to follow.

Equally important, we ought to recognize that the CAM professions overlap each other and overlap

conventional medicine. Speaking as a naturopathic doctor, I suture wounds, I take out splinters. Is that conventional medicine because conventional medical doctors do it? And conversely, if a medical doctor prescribes glucosamine sulfate because it is more effective than many of the NSAIDs, is that all of a sudden not appropriate in CAM?

I think that the point I would like to see us get to is that each system of healing must have high-quality education that ensures its practitioners understand and effectively practice their modalities, and that these modalities be consistently applied, consistently evaluated and tested by rigorous modern science.

So, some hands are up. Jim, and then Tom.

DR. GORDON: I would just like to, although I appreciate the distinctions, I would like to add another perspective to the whole issue of CAM or not CAM. I see this very much as an evolutionary process and that we are evolving toward a medicine and a healing that is much broader than any of the systems that we now have in play.

I think that the time is coming that as things

are proved, they will be included in different ways, but right now we are at a particular political juncture and a kind of ideological juncture where we need to call attention to those things that are outside of conventional medicine because conventional medicine is limited, and because it has had in some ways blinders on in looking at these other approaches.

I think that may always be the case, that there may always need to be some kind of National Center for Complementary and Alternative Medicine because any orthodoxy tends to be blind to anything that is outside of the orthodoxy.

So, in a sense what we are talking about is enlarging the boundaries of medicine and healing in a variety of ways. Now, we may come to a point at which the orthodoxy is open to and embraces all other systems of healing and treats them with equal respect, or we may not, but right now we are not at that place.

MR. CHAPPELL: I have been waiting for some time.

DR. PIZZORNO: Tom, you are next.

MR. CHAPPELL: I think Jim is right, that we

are at a particular point in our cultural life, and it does need to be so named as it is, but we also in the recommendations have decided that we would be visionary and be talking five and 10 years in terms of our context.

So, 10 years from now, how our particular systems resolve care or healing will be different in terms of the methodology, than the methodology we understand today as being standard. So, I would just say perhaps we are going to evolve to a distinction between natural medicine and standard medicine.

DR. PIZZORNO: I followed you until the last sentence. Would you go again?

MR. CHAPPELL: I am suggesting that the CAM modalities lead to, once they are proven and have the kind of efficacy that we are seeking, they become categorized as natural medicine as distinct from standard medicine.

DR. GORDON: Since I started this piece of the discussion, just two sentences. One is I see us evolving in a direction in which those distinctions may not be the most important distinctions at all, that the distinctions may have to do with very different things, for example,

that we may conceptualize medicine quite differently.

If we go back to our Hippocratic roots in Western Medicine, for example, and we pay attention to those principles, and we really apply those principles, then, we understand that we only use drugs and surgery in extreme instances, and that we tend to use self-healing as the basis of our health care.

So, I am looking for a larger, no more of a dichotomy, but more of a system in which different, sort of basic principle are invoked, and that all of the different systems of healing have the capacity to participate in this larger system.

DR. PIZZORNO: Effie, and then Charlotte.

DR. CHOW: Thank you. The gist of the conversation has mostly been the fact of integrating CAM into medicine, that it becomes medicine once it is proven, so it's second rate. I know I was brought up that Chinese Medicine was second rate in my young days and that it was not to be listened to.

So, in a sense, we are putting CAM under that category, too, in a sense. When it is proven, then, it can become medicine. Well, the discussion here was, on

the term, was it becomes part of medicine.

We are not only talking about medical school, we are talking about all health professionals. Then, we did talk about that we are really dealing with health and lifestyle, all of that. That seems to get dropped away often in our conversation.

So, what is it, is it a one world health care, lifestyle, and getting away from medicine? I just want to go back again. A lot of this kind of chaos in thinking is lacking a clear definition of where CAM is and the direction of CAM.

Anyway, I want to reinforce that it isn't medicine we are really talking about, it really is an overall health and with all the other social aspects and lifestyle aspects we are talking about.

DR. PIZZORNO: Thank you.

Charlotte will be next, and then Dean. Clearly, we have opened up a huge unresolved issue with the Commission here in terms of definitions and such, and we will need to come to resolution on this.

Charlotte.

SISTER KERR: Thank you for that comment. I

think maybe this does move on to the next meeting, but I wanted to say something about our definition of science, and we have heard enough speakers to hear some of the discussion and controversy in that definition.

Certainly, Dr. Russ Roy and Friends of Health spoke to this, but I would say we are evolving in this definition of science and that we are enlarging the boundaries of science, and it is my opinion that it is actually this philosophical and changing scientific or present scientific framework that is making it difficult for us to speak in the areas of soul and spirituality, which is an area that we still haven't quite included yet.

I just wanted to make that point now. Thank you.

DR. PIZZORNO: Dean.

DR. ORNISH: I just think that part of the problem may come with the very words "complementary and alternative medicine," and we have heard many people testify that we should be thinking more in terms of terms like "integrative medicine" rather than CAM, because CAM, by its definition, is something outside traditional

medicine or Western allopathic medicine.

I would love to see a report titled something like towards an integrative medicine, and then it gets away from the kind of judgmental things that Effie was talking about. It is not second rate because there are many things in allopathic medicine that are unproven, just like there are many things in CAM that are unproven and that we are really talking about leveling the playing field, applying the same standards of evidence based, whatever we end up determining is evidence based, across the board, and integrating them, and then it addresses the issues that Tieraona raised, is if it is glucosamine, it becomes part of standard medical practice, then, we are really integrating it, and we don't have to then arbitrarily say at what point does it cross the line from being alternative to traditional, that there is a whole spectrum that we are really trying to move everything, the unproven parts of allopathic, the unproven parts of CAM towards an evidence-based approach and integrating the best of everything that works and finding the best systems to use for any given patient.

DR. PIZZORNO: Thank you. I think that is well

said. I want to follow up also on what Jim said. Are we here because we want to develop the best medicine, and I think we recognize the huge value of pluralism in health care, that each of these disciplines has its place, and we want to have each of them evolve and if some of us get some parts of the answer better than others, the others should be able to use it, and we should not lose that individuality and pluralism.

Joe Fins, and then Veronica.

DR. FINS: Thank you, Joe Pizzorno. I think this has been very interesting because there is like a sociology issue here. You know, there are things that work and things that don't work. There are things that are safe and things that are unsafe. That is sort of a universal.

But what is different is the sociology of how glucosamine got to patients with arthritis versus nonsteroidals. I think that is something that we might want to just put in the Final Report, that we can have the same endpoint, have different ways of getting there, and that the different paths have different challenges and different opportunities, but it is not the science

that is different, it is not efficacy that is different, it is the history of the progression of the discovery to the clinic.

I think there are the market forces, there are different paradigms, I mean there are lots of reasons why it is that way, but I think we are sort of getting focused on whether glucosamine should be treated any differently than a nonsteroidal.

The answer is no, but I think the reason we are having this discussion is because we somehow have to straddle two different historical paradigms of how those agents got to the bedside.

DR. PIZZORNO: Okay. Charlotte, just a real quick thing, and then on to Veronica.

SISTER KERR: I just want to know, what you just said, you said it da-da-da-da, it is not because our science is different, but so-and-so. Am I the only one sitting at this table who thinks maybe there is some kind of different science? It is really, truly just a question, because of what I just said before this.

Are we not questioning the definition of science at all as we understand it for the last bit of

history? Dean summarize it all by defining it under science, and then there would be one kind of medicine.

DR. FINS: My comments were limited to the question of the evaluation of a therapeutic agent. I mean I think we are products of Baconian science. I mean that is sort of the paradigm that the Western World at least is in.

Does it mean it is an exclusive paradigm? Probably not, but there are other ways of looking at these issues, but that is a philosophical question that won't be in the Interim Report. It is used, so I don't think we can really address that now.

DR. PIZZORNO: Do you want to answer it?

DR. FINS: I can't answer that.

DR. PIZZORNO: Thanks, Joe.

Veronica, and then Jim.

DR. GUTIERREZ: Words are very powerful, can be very powerful, and I think when we talk in terms of training, education, credentialing, and so forth, we need to choose our words carefully.

I personally don't think we will ever have a level playing field when we use the term "medicine,"

because there is a lot of people who contribute to health, who aren't in that classification.

I am very comfortable with, for example, a term like mainstream health care, which could encompass everybody and make them comfortable, but medicine has 100-plus years connotation to the word, and not everybody would be comfortable under that umbrella.

DR. PIZZORNO: Bill, one last comment, and then I want to finalize this recommendation.

DR. FAIR: Unfortunately, I didn't hear all of Tieraona's comments, but I think the glucosamine story is a very appropriate one. The use of glucosamine didn't arise from the medical profession. Consumers were using it, and like any leaders, the doctors said let's find out where the people are going and get in front of them say follow me, and basically, that is what happened.

So, it wasn't the clinical trials that showed that glucosamine was good, and that is why people used it, so I think that we have to be aware that some of these things will arise just from common usage or traditional healing or whatever.

Secondly, I am a bit concerned about the term

"integrative medicine." We gave a lot of thought to the type, of what we would call our center when we opened it in Soho, and integrative medicine, the connotation I found, at least in the New York area, was that meant doctors practicing CAM medicine. It is another topic, but I don't think doctors can do it well and physicians can do it well.

I think that something like complementary more fits the bill. I am just afraid if we use "integrative," we would be sort of endorsing a physician-controlled system.

DR. PIZZORNO: So, let's get back to what was the original intent of, number one, basic undergraduate, graduate, and continuing education in CAM curriculum.

I think, number one, as Joe Kaczmarczyk reminded me, that is to ensure that all practitioners, regardless of type, can talk with their patients about CAM, number one. So, the medical doctor needs to be able to advise their patient about CAM practice.

Conversely, I believe very strongly all CAM practitioners must understand conventional medicine well enough to talk with conventional medicine practitioners.

My experience has been that so much of the distrust that has evolved between conventional and alternative medicine has been the lack of ability to talk to each other and also the fact that we tend to see each other's failures, which gives us a skewed perspective.

So, looking at this recommendation as stated here, and realizing that our intent here at this stage at least is to recommend, not mandate, is there anybody that can't live with what we have right here?

DR. GORDON: I would just like to add that I think it is talking with, it is also appreciating the limits of one's one abilities. I think this is a crucial area that everybody needs to understand what they know about and what they don't know about, and also finally, the other element is to be able to refer to other people intelligently.

DR. PIZZORNO: Perhaps a better term consistent with what Bill had said, was I much prefer the term "collaborative medicine" rather than "integrative medicine," because collaborative medicine recognizes we each have strengths and weaknesses, and what is best for our patients is to talk to each other and figure out what

is best for our patients, not to alienate each other.

Joe Fins.

DR. FINS: Just on the referral issue that Jim mentioned, I just want to hammer home again the importance of referral in allopathic and in CAM therapy to palliative care when patients are terminally ill and dying. I mean there are resources that are available for end-of-life care in palliative medicine in the hospice situation, and people can be diverted from that by both allopathic and conventional CAM practitioners, and we need to be attentive to that referral for people who are desperately ill, whatever the paradigm.

DR. PIZZORNO: George.

DR. BERNIER: I think it would be helpful if the words "evidence based" was associated with the curriculum.

DR. PIZZORNO: George, I am going to take a slight disagreement with you, not because I don't agree with evidence based.

DR. BERNIER: It wouldn't be the first time.

DR. PIZZORNO: Actually, I think we have agreed on most things. Oh, well, anyway. I am absolutely

committed to evidence-based medicine rather than conventional CAM.

DR. BERNIER: I think that is a great way to say it, the way I said it.

[Laughter.]

DR. PIZZORNO: So, give us some wording for the solution that if there is a practice out there that does not have evidence, but the medical practitioner must know about its presence, how do we tell them if it is not evidence based? You are saying if it is not evidence based, we can't tell them about it, we have to tell them it exists.

DR. BERNIER: I am sure we could make an exception.

DR. GORDON: George, I thought that what you meant was an evidence-based approach, so if there is evidence, that evidence is produced, if there is no evidence, one simply says that there is no evidence.

DR. PIZZORNO: Then, we are in agreement, that is fine.

DR. FINS: On this line, you know, the United States Public Health Service, all those things for

prevention, and they have, you know, there is A, B, C, D, that might be a very helpful model, and different groups have different recommendations like the American College of Physicians, ASIM about mammography versus American Cancer Society versus U.S. Public Health Service.

There was this chart in the Annals of Internal Medicine a few years ago that sort of folded out for every period of life and who said what, and that might be a model worth looking at as an analogy for what we are talking about here.

DR. GORDON: Or another way to think about it might be to say that people always have some evidence on which they base their approach, so the question is what is the nature of that evidence and what is the quality of the evidence really.

That opens up to other kinds of evidence than perhaps conventional science has, so it is simply a matter of stating what evidence there is and making that available to people who are studying that approach.

DR. PIZZORNO: I think that is an excellent recommendation, George, so that this education clearly defines the level of evidence available for these kinds

of practices.

Would that meet what your intent is? Okay.

Any other comments? Tieraona.

DR. LOW DOG: Is it appropriate to mention in there, in addition to just CAM curricula, that medical schools attempt to define the traditional practices that are practiced in their area in their patient populations?

It is a big issue for us in New Mexico being familiar with the indigenous populations there and the hispanic populations, so that there is an understanding of the different treatments and the different modalities that are used.

I mean it can be relevant. We had a child who a social worker was called in for child abuse because they had done coining on the child, which if anybody just would have understood what that was, a whole terrible thing could have been avoided.

So, because we are such a diverse culture in the United States, I would like to see just making some sort of recommendation.

DR. WARREN: What is coining?

DR. LOW DOG: The child had a bad like

pneumonia, bronchitis, and they had taken the warm coins and had placed them to help break up the mucus and the congestion, and it didn't burn the child, but it left small rings on the back where you could definitely see. The social workers were called in. The child was held in protective custody for several days.

It was just a terrible sort of thing because it is just a very deep part of traditional Vietnamese healing, and nobody was abusing anybody, but because the ER staff didn't know anything about our very large Vietnamese population, they had no idea what this might have been from.

Again, I am just sensitive to a lot of the use of the Curandismo and the different diagnostics that hispanic people use, as well, and I think that it is something that has been really left out. I think it hits right to the heart of what CAM is, which is traditional practices, and we have many of those here in the states.

DR. PIZZORNO: Any other comments, recommendations?

[No response.]

DR. PIZZORNO: Great. We will nail that down

and move on to the next one.

No. 2 on page 4 is parity of CAM professions and practitioners with conventional health care professions in access to educational and training funding and other resources. I would also add to that "comparable accountability." So, I think not just having access to funds, but also accountability for their education and the use of those funds.

Any comments about this recommendation?

DR. GORDON: Joe, just to open it up a little more to thinking about it, when a recommendation like this comes up with which I basically agree, and you begin to think about making this recommendation to Congress or to the administration, you start thinking about money, at least I start thinking about money and limited resources.

So, I am really opening this as an idea for discussion, do we want to make recommendations that we know are going to cost a lot of money and cause a lot of tumult, which we may, or do we want to make limited recommendations, how do we want to approach this as a commission, and it is applicable here, and there are several other areas where it is quite applicable, as

well. I just raise that question.

DR. PIZZORNO: Tom, Tieraona, George, Joe.

MR. CHAPPELL: I think this is one of the highest priorities among our recommendations is to create equal access to all aspects of being a good practitioner, so it really, for me, it doesn't matter whether it is controversial or going to raise questions about additional funds.

As I said earlier today, I think we have to be proactive about raising and allocating more funds for this area of wellness and health, and so this would just go along with that. Perhaps we need to make a statement right upfront in our introductory section of our report that CAM practices and products are a value-added to what is available as described by 42 percent of Americans that are currently engaged in paying for these services, or the $30 billion that constitutes the marketplace for these services.

The value of these services has been already demonstrated by consumers, so I think the cry here is for better research, better education, better services, and the only way we can raise up the CAM professional is to

give them equal access to the funds.

So, I see this as so fundamental I certainly wouldn't want to postpone it. I would like to just face it head on.

DR. PIZZORNO: Tieraona.

DR. LOW DOG: Mine is a simple question. Are you talking about licensed professionals only here, and is it all licensed professionals, just for curricular program development inclusion and loan forgiveness, I mean so massage and acupuncture, that is strictly what we are speaking is licensed providers?

DR. PIZZORNO: I think that you have raised a good question we should discuss, because clearly, there are those schools that are accredited or licensed by the states and have licensed practitioners.

There are other groups out there, as well. I think we should facilitate their evolution, as well. I think the idea of establishing an Office of Emerging Professions, for example, under the federal government, to facilitate the maturation of each of these healing arts, particularly those who aren't as far advanced as naturopathic medicine or acupuncture or chiropractic, to

me makes a lot of sense. Again, it is up for this commission to decide on that.

George.

MR. DeVRIES: I see a lot of value in this approach, but I am also challenged by how it is going to be received in a report to basically say there has to be parity on all levels in a variety of areas.

I think if you compare medical physicians with dentists, you don't see dentists having parity, and yet you see significant access to resources, and it seems as if, while it may seem like settling for second best to take a more incremental approach, at least perhaps that is a start and heading in the right direction, and can be demonstrated over time, the value of an incremental approach and be grown over time.

DR. PIZZORNO: Perhaps one way of looking at it is rather than mandating exact parity, it would be to look at legislation which currently excludes CAM institutions from access to federal programs. That is a real issue, because so many clinical programs say only M.D.'s, only DO's get them, nobody else can have access to them, so may be an incremental step, but just remove

the exclusions.

Joe.

DR. FINS: I think this is a tough one. I am not sure what you mean by parity with respect to resources. I mean you could say, well, NCCAM gets $100 million now, the NIH budget is $20 billion, so we should ramp it up to $19.9 billion.

DR. PIZZORNO: All in favor, say aye.

DR. FINS: But I think this really is going to be I think difficult to sell to people. I mean people have different amounts of training and there isn't parity in anything in our society. I think we need, I agree with George, a more incremental approach, and Joe was just saying, I mean as an idea, you know, there are ways of having collaborations to increase cost effective ventures in this new paradigm with health, but I think to go for parity, I mean I can't imagine the entities that represent organized medicine having a great deal of comfort with that.

Of course, I think if we are looking, and I don't think it is justified at this point. We heard testimony from different practitioners from the same

discipline, from different schools, who couldn't agree on the number of hours one needed to train to be an acupuncturist.

So, I am not sure if there is a consensus or there is standardization yet to really say, you know, that they should have parity with entities that have formalized curriculum and a methodology and licensure, accreditation and re-accreditation, so I mean I think there are lots of issues here, that there is not equality, ready for parity.

I am in favor of integration, I am in favor of cross-training, I am in favor of collaborations, but parity seems a little too extreme.

DR. PIZZORNO: Dean, and then Tom.

DR. ORNISH: I know I am sounding like a mantra here, but I really think this would a perfect issue to table until October because there is a lot of controversy about it. You know, it is not a question of the merit of the idea as it is being mindful of the fact that you probably couldn't pick a bigger land mine than this one.

If you want to just put it out there and step on it, at least do it with your eyes open. Maybe I am

just getting old, but I really think that there is value in incremental approach, because otherwise we can take a polemic and end up with nothing, or we can try to say let's really be skillful about change.

We heard this morning how it took five years from the time the patients' bill of rights was introduced before it got passed last month, and that is kind of a hard thing to argue against, the patient should have rights, you know, so I am taking more of a long view here, and I think that if we don't avoid these land mines, we are going to just end up with a lot of rhetoric and nothing to show for it, and I would really encourage us in the Interim Report to avoid those kinds of things if we can.

DR. PIZZORNO: Before I move on to Tom and Charlotte, could you give some examples of some incremental approaches that might be useful?

DR. ORNISH: Well, there are a lot of them. I am more just trying to be the red flag and say look, you know, you don't wave a red flag in front of a bull and then say, hey, how come the bull is charging at me. Just be mindful, be aware. There are lots of incremental

approaches. I mean many, many things have been said already, I don't need to repeat them - demonstration projects are just one of many.

I am just saying that our committee is a pretty pro-CAM committee as it should be, but if we hear people like George and Joe and other people who are raising these issues, we need to listen to them, and say, look, if they are raising these issues, you can be sure that AMA is going to be raising these issues and other organized medicine, and the stakeholders who view that there is a limited pot of money, and if you are going to be increasing the money for other people, it means you are going to be taking it away from them.

Whether that is real or not is irrelevant, that is the perception, and I think that we ought to have an Interim Report that we can all agree on, that we don't have dissension in our committee, that we can say, yes, this is really good, that we don't make ourselves easy targets and then as we build up the groundswell behind our support, support behind what we are recommending, because it just makes sense like freedom of choice and the kinds of things that we heard about this morning,

then, it becomes much easier to take it to the next incremental level.

But if you try to do too much too soon, you go nowhere, that is all I am saying, just let's try to, for the Interim Report, just find consensus, and then for the October report, we can decide how much we want to go out on a limb.

DR. PIZZORNO: Thank you, Dean.

Jim has a point of information.

DR. GORDON: I just wanted to mention as a point of information, what we have done with the draft of the Interim Report is to raise this as an issue without saying where we come down on it, so in a sense, we have done what you are suggesting, saying that it is an important issue -- at least I believe we have -- saying that it is an important issue, but it is not one we are addressing in the Interim Report, but that it is something, I think as we say pretty clearly, it is something that people have testified to wanting.

DR. ORNISH: I was only respectfully disagreeing with Tom when he said he felt so strongly about it should be in the Interim Report.

DR. GORDON: I understood that.

DR. PIZZORNO: Tom.

MR. CHAPPELL: I believe the problem word here is "parity," and at least in the interview that I had for today's meeting, I was talking about equal access, equal opportunity. I have a hard time speculating that anyone in this room, or even anyone reading the report, would have trouble with the idea that a CAM practitioner should have equal access to the same sort of funds for education and development that another medical professional would. So, it is really not parity, that is the problem word, it is equal access and/or opportunity. Perhaps it is just equal access.

I think if we don't put it in the Interim Report, we get criticized for suggesting elsewhere in the report that we have expectations when we haven't even thought to cover the basic homework of needed training, needed development, and more knowledge in general.

I just can't imagine that anybody would want to deny the necessary steps of full development, so I would change the word, and I do think it really needs to be part of the Interim Report.

DR. PIZZORNO: Thank you, Tom.

Charlotte.

SISTER KERR: I just want to say I agree with Tom, and I would also honor what Deans says, however, schools have met state requirements of credential for Master's programs, have national standards, say, like acupuncture schools, hey, you know, change parity maybe, but you certainly have equal access to funding.

DR. PIZZORNO: Joe, and then Jim.

DR. FINS: Just briefly. To put this into context, the last line in the Interim is talking about the federal loan forgiveness, the scholarship programs that are now available to students of the conventional professions, well, this has been dramatically cut back and we have to contextualize how this will be received in the context of the diminution of resources for conventional practitioners and medical students to get these kinds of loan forgiveness programs.

DR. PIZZORNO: Jim.

DR. GORDON: I think what I wanted to say is that, by definition, the Interim Report is going to represent areas where we have consensus, so that is

something that we have consensus, that we are going to have consensus in the Interim Report.

So, what I am suggesting, which I suppose goes with what Dean is suggesting, is that in those areas where we don't have consensus, that we really need more time and more discussion, and need to really grapple with these issues in a different way, and then we can figure out how we are going to deal with them.

If we come to a consensus about this, then, fine, it could be in the Interim Report, but if there is not a consensus, my feeling is the Interim Report is the representation of our consensus at this time.

DR. PIZZORNO: Other comments or thoughts?

MR. ROLIN: I, too, disagree with the use of the term "parity," but I was certainly in favor of access, but it is just like we have said, when you get to the last part of that sentence there, when you are just seeking out and making that broad a statement, it is going to trigger the whole community as far as education and all that.

So, access is a key. I think it should be included, but, you know, inclusion to that extent, I

don't know if I am comfortable with that or not.

DR. PIZZORNO: So, I think I am hearing here that the use of the term "parity," which implies exact equality, is problematic for a consensus from this group. Now, I would personally go for it, but we want consensus. I want to be clear where I stand on this.

So, what other language can we use here we can develop consensus at? Now, we may not be able to develop consensus, but we have a little bit of time, let's see if we can. Tom and Buford both brought up the concept of access as being a better term.

Now, that access can take many forms. Equal access is one form, which is good. We can also use the term "increased access," which is a lesser term, but it does open some doors. To make a quick editorial comment here, clearly, the vast majority of health care in this country is provided by conventional medical professionals, however, a large amount of health care is being provided by the alternative medicine practitioners, and right now virtually all of the money for education, research, certification, advancement, et cetera, goes to conventional medicine. That does need to change.

I suspect there is consensus on that. So, the question then is how we come up with language that we feel will be accepted, but will also induce change.

Dean.

DR. ORNISH: I think for the purposes of an Interim Report, you want to avoid any relative comparisons. In other words, instead of saying this should have as much access as that, which immediately, if you are "that," you feel like you are going to get that taken away to be given to this, you say adequate resources should be provided for education and training in research and complementary and alternative medicine, something along those lines, a positive statement without making reference to anything else. That is just my belief.

DR. PIZZORNO: There is one recommendation. Are there other recommendations about the kind of language we could use, that we could get consensus around?

[No response.]

DR. PIZZORNO: Actually, I kind of like what Dean said. That sounds pretty good to me. Anybody else?

Joe.

DR. FINS: I would just add to that the word "accredited" or some sort of, you know, so we are talking about legitimate practitioners or people who are in accredited programs, or things like that. The people should be engaged in accredited activities, you know, accredited educational activities.

We get back to the licensure issue again. That is why there isn't parity, because you can't answer that question. You can't answer the question who is accrediting these people in all the circumstances we are talking about. In some cases, you know, we can, I mean in the acupuncture case, we might be able to do that; in other areas, we can't. So, making a broad sweeping comment about all CAM professions and practitioners, there is also a disservice to the heterogeneity. I mean it says the Bastyrs are like the mail order naturopathic medical schools.

DR. WARREN: Even though they are both accredited by the state.

DR. FINS: And even though they are both naturopathic physicians, and I think having been to

Bastyr, it is a disservice to -- you know.

MR. DeVRIES: Do you want to read what you have, that you are trying to get consensus on?

DR. PIZZORNO: Okay. Also, Donald, I want to be real clear, institutions like Bastyr have different accreditation than institutions like the mail order people, I want to be very clear about that.

DR. WARREN: [Off mike.]

DR. PIZZORNO: You may want to check to see who they are accredited by. Also, please use the microphone.

Here is possible language that I derive from what Dean just said. Adequate resources for CAM professions and practitioners to access educational and training, funding, and other resources.

Tieraona.

DR. LOW DOG: I think that Joe's point there about accreditation or licensed or something, it is going to have to be addressed somewhere, and it is different than access. I mean you can go see whoever you want, I would defend your right to the end to go choose who you want for your health care provider, but I am not sure that we want to really say just any CAM profession,

because I am not sure that I want loan forgiveness and that for iridology school, and I don't want to pick on that, I am saying that there are certain things that in a limited pool of money, may have more value than others, and the groups that have gone through accrediting their schools, I think that any of those students should have the same access as any student has in the United States to get money to pay for their education.

Loan forgiveness is a little bit of a different situation, and I don't think we have consensus on that, but I don't think anybody here would disagree that if you are going to go to school, you should have access for federal funds as loans that you can take out and repay. I might even feel the same way about iridology school for something like that, if you don't pay it back, I don't care what you do with it, but loan forgiveness in that, what we are going to pay for I think is a different subject.

DR. PIZZORNO: Jim, Tom.

DR. GORDON: One thing I want to say is what we are peeling away is the various levels of this discussion, which becomes very complex, and I want to

make sure that whatever recommendations we come out with in the Interim Report do not get us in over our heads, because I think the distinction here between repayable loans and loan forgiveness is huge.

The distinction between, that we still haven't solved, is which professions do we include in CAM, and do we make that public money available for, is also a big area of discussion. So, I just want us to be clear that there are real differences among these as we make these decisions. These are decisions that really make a difference, and we may not have taken account of all of the things that we are deciding about, and we are just hearing them now.

DR. PIZZORNO: Tom, you are next, and then George.

MR. CHAPPELL: For me, the statement of access versus parity would sound something like provide access of CAM professions and practitioners to educational and training, funding, and other resources. It is not a comparative at all. It is just providing access.

The marketplace will work that out. That peels away all the comparators, but it establishes the

fundamental principle that I feel that we are trying to do here.

DR. PIZZORNO: Thanks, Tom. So, now we have two ways of wording this. One is provide access for CAM professions and practitioners to educational and training, funding, and other resources, and the other is provide adequate resources for CAM professionals and practitioners to educational and training, and other resources.

George.

MR. DeVRIES: This obviously may be a small land mine even within this room, but reality is part of the incremental approach in terms of the funding, part of the ability to sell this to Congress, part of the ability I think almost necessitates that the funding be limited to CAM practitioners who are licensed, and it would have to be provider types who can be licensed.

DR. GORDON: Could you say why you are saying that, George?

MR. DeVRIES: Well, I think part of it is you have a regulatory body in the states that is overseeing the licensure of these individual providers, and that

provides part of the standards in terms of the profession, also in terms of the educational curriculum, and that draws down to the accreditation process of the school, ultimately even to the ability of the provider to get reimbursed, because even as we heard in testimony, very often -- well, I shouldn't even say very often -- but typically, the health plan, if they are going to cover CAM, it is going to be limited to providers who are licensed.

So, that line draws across a variety of spectrums.

DR. PIZZORNO: Effie was next.

DR. CHOW: I would just like to reflect back on what Jim said, that we are reflecting what has been stated by people who testified, and that we are not really speaking only as commissioners, but we are really relaying the message of the people.

So, in a sense, I think we have to be careful with words, but we can't water down everything because it is going to offend the Congress. I am not saying that it needs to be in the Interim Report, but I think I would like to see we not neutralize things so much that we are

not going to make great impact to, as well, and that we do have the obligation to reflect what the people have said, and the people have said some very strong things.

We need to portray that, as well as the other, more mild things.

DR. PIZZORNO: Thank you.

We are getting close to the end for this particular one. I would like to, one, suggest some wording, and actually I really like the way Tom worded it, but also I would like to put one more piece on the table before finishing this, and that is do we restrict this language to licensed professions or not.

I would like to start the conversation with a comment. On the one hand, I certainly can see the value of restricting it to licensed professions, and it certainly resolves a lot of thorny issues about deciding who gets qualified and who is not, but on the other hand, I feel a very strong commitment to those other healing arts that have not yet progressed to the point of formal education, accreditation, licensing, and such, that we give them a helping hand up, so they can evolve, that needs to be handled.

Now, as Joseph just said, this may not be the place to do it, but it is something that I think we need to do. Those iridologists, for example, I have major doubts about whether it has any validity or not, but, you know, they need to progress to a point where we can determine it they have validity or not, because there may be something there that will be useful for health care.

So, I would like to just kind of see is there something we can say or do we just postpone it for another time?

Tieraona, and then Bill.

DR. LOW DOG: Well, I don't know, it seems like if you go to an accredited school, and I mean there are herb schools that are accredited by their states, where we don't have any licensure for herbalists, but it is an accredited school meaning that it has got ways of tracking faculty and students, and I mean I was part of that, so I know what we went through, but you are not licensed.

I guess what I was saying earlier was I think anybody who is going through an accredited school should have the right to apply for federal funds that they

repay. I mean it is at a lower interest rate, and I don't know why you would separate that out from a vocational school or for anything else. If it is an accredited school, and it has met accreditation, whether it leads to licensure or not, I think -- again, I have separated it out, I am saying that for repayment, you are getting a federal loan at a low interest rate -- I think anybody should have access to that just as a student.

DR. PIZZORNO: Tieraona, there is some language here I think we have to be careful about, and that is the term of accredited and licensed by the state to run a school. A lot of people use the term "accredited" when a state says yes, that school can run, but that technically is not accreditation. It is simply approval by a state to allow them to run. Accreditation is a separate process that has direct ties to either the federal government or to there is an accreditation of accrediting agencies.

So, I just want to say we need to be just a little careful about some of the terminology here.

DR. LOW DOG: I will leave the terminology for you, but if I can get repayment to go learn to be a

plumber, I should be able to have access to that in a country that supports education as long as the school itself has met the criteria that it is able to educate, and it has follow up.

That is very different than loan repayment, it is very different than licensure, it is very different than all of that, but I think people would have a hard time disagreeing, because you are paying back the money.

DR. PIZZORNO: Bill.

DR. FAIR: Well, I agree with Tieraona, and I know George is coming from the idea because we had this in our small group, that licensure is the only way to get reimbursement, as it was for the chiropractors.

But I think that, I don't know whether the term "accreditation" or "credentialing," or whatever, but the standards for adequate education in a modality has to come from the practitioners in that modality. The state can't set those standards, the state can license it.

So, I agree that whether it -- again, I don't know whether it is credentialed or accredited or something like that, but if the practitioners in a given discipline like yoga and movement therapies, or herbal,

or whatever, have established criteria that they would think would adequately train a person, it would seem to me that they should be eligible for the same benefits whether or not the state -- George, I may be misquoting you, but it sounded to me the main reason for licensing when we talked in the small group was for reimbursement.

MR. DeVRIES: I wouldn't say the main reason for licensure is reimbursement. I am saying that licensure is a prerequisite to reimbursement, and licensure involves a variety of things related to basically the provider being able provide services, being legally empowered to make a diagnosis and provide care for patients.

There is a variety of reasons you have licensure, but licensure is simply a prerequisite.

DR. FAIR: But the state is not setting those criteria, is the professional board, whatever it is, and then the state says, okay, they have gone through an accredited school or credentialed school, and therefore they are eligible for licensure.

MR. DeVRIES: Right.

DR. PIZZORNO: Let me take a stab at some

language here, because this is going to be a little tricky, because I want to accomplish what Bill and Tieraona have said, but how to do the exact language is a little tricky, but I will just take a stab at it.

Provide access of licensed or accredited CAM professions and practitioners to educational and training, funding, and other resources.

DR. FAIR: Joe, do you know the difference between credentialed and accredited? I mean I don't know, I am just asking.

DR. PIZZORNO: Yes, I do.

DR. FAIR: What is it?

DR. PIZZORNO: In the strictly academic term, accreditation is a process of approval of an educational institution or program within an institution. That strictly is accreditation, and it is actually independent of licensure, certification, et cetera. That is strictly an academic definition.

DR. FAIR: What about credentialing?

DR. PIZZORNO: Credentialing, in general, licensing is done by states, credentialing is done both by states and by professional organizations, and

depending upon the situation, in most situations, only credentialing by a state is meaningful, but there is some credentialing in some medical specialties that the medical specialty credentialing board is significant.

SISTER KERR: Does your statement include schools?

DR. PIZZORNO: I assume the term "professions" would include schools.

So, can everybody live with this? We will leave it to staff to maybe tweak the language a little bit more.

So, I will say it again. Provide access of accredited or licensed CAM professions and practitioners to educational and training, funding, and other resources. I am including in professions, institutions, as well. I think that is the intent, but maybe we should explicitly state that.

Can everybody live with that? Is there anybody that can't live with that? Going - going - gone. Okay.

DR. FINS: Hold on. Hold on.

[Laughter.]

DR. FINS: I think it is implicit in what you

said, but the loan forgiveness component, that is tied to service to underserved is not something we are talking about here.

DR. PIZZORNO: We are not specifying anything. We are just presenting a general concept.

No. 3. We have 20 minutes left for No. 3, and then we give it to Jim to make the summary. This is on page 5, joint and cross-training of CAM and conventional health professions in undergraduate and graduate programs. Again, we mean by "undergraduate," before they get their degree, and "graduate" is after they get their degree.

I would just like to start this conversation by again reminding people of what I think is the direction we are moving in, and that is collaboration of these health care professionals, and I think joint training is one of the most effective ways in which we can accomplish that.

Comments? Dean.

DR. ORNISH: Well, it is one of those ideas that sounds great in theory, but it is hard in practice because it could be very easily viewed by the

conventional training programs that you going to mandate that they take some of their resources and allocate them for CAM. It is just another land mine.

I am just the messenger, so don't shoot me here, but I am just telling you that is how it is going to get viewed.

DR. PIZZORNO: Okay. So, let's be careful. We are not mandating this, it is just something we are recommending. By the way, this is doable, because we are already doing it.

DR. ORNISH: But the difference between a recommendation and a mandate is going to be lost on those constituencies, that's all. Again just be aware of it.

DR. PIZZORNO: Joe Fins.

DR. FINS: It does pose a lot of logistical questions and problems on how to operationalize this. Maybe if we just said, you know, like consideration of demonstration projects that would allow us to learn how to do this kind of thing, and leave it at that.

It doesn't threaten any current training programs, and the details will be worked out, but I think this is the kind of thing where a demonstration project

is an incremental, less threatening, more feasible step.

DR. ORNISH: I mean by analogy, it took us seven years in dialogue with HCFA before they would do a demonstration project of our program as an alternative to bypass or angioplasty, and we have done randomized trials, and we have done everything, and it still took seven years, and we are still just getting started, but the language demonstration project, for whatever reason, doesn't seem to push people's buttons, so I am agreeing with you.

DR. PIZZORNO: Jim, George, and David.

DR. GORDON: Just one thing that I would like to mention. In this area in particular, there are a number of examples where we are already doing this. We are doing this at Georgetown, for example, and have been for a number of years.

Other medical schools, other CAM schools are doing this, so I think if we couch this in the language of what we are already doing, we will be moving along much more easily, and these are demonstration projects.

Incidentally, NCCAM has a whole program to fund such demonstration programs already, so I think this is

one of those places where we can take, just as I said in the notion of recommendations, that this recommendation will go down a lot more easily and be a lot stronger with the evidence that we already have accumulated of projects that are doing this.

When it is cross-training, I think we also have to make clear, and I think the fear that will come up is, well, they are going to come in, those others are going to come in and take over my program, and I think there will be that fear from all sides.

I think as we focus on making recommendations, we have to be pretty clear about what we mean. This doesn't mean that the M.D.'s are going to come in and take over the school of Chinese Medicine, there are already M.D.'s who are teaching in schools of Chinese Medicine, or that the acupuncturists are going to take over the medical schools.

This is one where I think we can go a long way, but we have to be careful in how we word it and describe it.

DR. PIZZORNO: George.

DR. BERNIER: I would strongly support it. I

think that it doesn't promise a whole lot of very specific things, and I think that maybe should be a model for what we put forth for the whole program, so I would support it.

DR. PIZZORNO: David.

DR. BRESLER: Well, again, I think here is something that can be looked at in the broader context because we don't have much joint and cross-training in conventional medical specialties either.

In my field, which is pain medicine, if you were to bring a headache patient into the medical center and ask a neurologist, a dentist, a psychiatrist, and psychologist, an orthopedist, and a physiatrist, you would find very, very different diagnoses and treatments.

So, I think this is an important consideration, I think we can thread it to a much larger issue that we also want to support.

DR. WARREN: My experience has been with postgraduate stuff where, as a dentist, we went into the osteopathic school and learned from teachers of osteopathy, manipulative medicine, but it didn't mean that we, as dentists, would take over osteopathy. In

fact, I think the dentists incorporating osteopathy into their practice has really strengthened the practices of osteopathy and the osteopathic field because we are now proponents of that treatment, and when we find something in our practices we can't handle, our limitations, then, we know who to refer to.

It is really building a tremendous rapport and bridge between the osteopathic community and the dental community, but it is being funded, not by the schools, it is not being funded by the federal government, it is being funded out of our pockets, continuing education, 3- to $500 a day for education, and we pay it out of our pockets.

I don't think we have to worry about the funding on this issue right here. The funding on the postgraduate level will come out of the practitioner's pocket, and I think it is taken care of.

DR. PIZZORNO: Other comments from the group?

[No response.]

DR. PIZZORNO: Just a comment. At Bastyr, we get a tremendous amount of requests both for residencies and for student experiences in our teaching clinic, and

we have developed an interesting policy that we are delighted to let them come into our teaching clinic if you will allow our students and/or residents have an equal amount of time in your teaching clinics, and they are saying yes.

So, I think there is a lot more interest in this than people realize because the students and more and more the faculty want to see this happen.

Any other comments?

[No response.]

DR. PIZZORNO: So, let's look at this language. We obviously don't want it to sound like a mandate, so we can use terms like "recommend" or "facilitate." So, how about somebody giving us an adjective here? Provide? Okay.

So, I will read the statement. Provide joint and cross-training of CAM and conventional health professions in undergraduate and graduate programs.

DR. BRESLER: Encourage.

DR. PIZZORNO: Provide and encourage?

DR. BRESLER: Encourage.

DR. PIZZORNO: Just encourage.

DR. BRESLER: Encourage and support.

DR. PIZZORNO: Encourage and support.

SISTER KERR: [Off mike.]

DR. PIZZORNO: We have a differentiation in terms here between provide, and encourage and support. So, what do we want?

DR. GORDON: I am not clear yet how this is different from No. 1. I don't know that we have made it clear.

DR. PIZZORNO: No. 1, this is specific to cross-training. That is people trained together and doing things of this nature. The other is making sure that those subjects are being covered. So, these are definitely different flavors.

DR. GORDON: What is the difference between cross-training and make sure it is covered? Could you make it more explicit?

DR. PIZZORNO: For example, in a conventional medical school, you could have a two-hour course, which is a survey of alternative medicine, and I have been teaching at the University of Washington for over 10 years. Conversely, you can have a student at the

University of Washington Medical School enrolled for a quarter at Bastyr, and a student at Bastyr enrolled for a quarter at the University of Washington, or have a University of Washington resident go to the teaching clinic, an acupuncture resident go to the medical school for rotation.

DR. FINS: I think the difference, Jim, is that you are asking people from outside each other's CAMs to come into each other's CAM, and that is why I think it has to be done, the language has to be non-threatening, so encouraging versus requiring would probably go further with a little bit of honey.

DR. GORDON: I think it also has to be clearer exactly what we mean, too. If I get taught acupuncture at Georgetown, that is not cross-training.

DR. PIZZORNO: Correct.

DR. GORDON: But if I go from Georgetown to traditional acupuncture institute, that is cross-training.

DR. PIZZORNO: And conversely, traditional acupuncture institute comes to Georgetown, that is cross-training, because they then are actually practicing

together. I think the key element here is training together, so that they will practice collaboratively.

DR. GORDON: And then if we both go to Joe Kaczmarczyk's outpatient clinic at the Public Health Service Hospital and work together?

DR. PIZZORNO: That would work.

DR. GORDON: That is also cross-training.

DR. PIZZORNO: That would work, yes.

DR. GORDON: I think we need to define, I just feel like it needs to be made much more explicit what we are talking about here, and how and why it is different from what we were talking about in terms of everybody having to know something about the other world view and the other practices. It just feels like it needs to be really fleshed out, and a rationale has to be given, so that it makes sense, too.

DR. PIZZORNO: I guess I would look at the staff and say I think Jim has made some good points, do you have enough information to strengthen this wording or would you like some more from us, more guidance? Michele, did you want to say something?

MS. CHANG: No, what I was hearing a little

bit, it was that if we provided a little bit more background in terms of the intent and purpose of the curricula element that we are discussing, it might be helpful for people to understand both the difference and kind of the overall background and rationale that Jim mentioned.

DR. PIZZORNO: Joe.

DR. FINS: Something like recognizing the need for improved communication and collaboration between allopathic and non-allopathic providers, we encourage the joint collaborative ventures we are talking about.

DR. GORDON: I think it is important to keep it open enough because otherwise we run into potential turf battles and people will feel offended. Tieraona is nodding her head. She and I have probably each spent -- I have spent longer than she has -- but each of us has spent 20, 30 years studying natural medicine, so to say I can't teach natural medicine at Georgetown Medical School doesn't feel fair to me.

DR. PIZZORNO: That was not the intent of this at all.

DR. GORDON: No, I understand. I am trying to

make it explicit, so that what we are doing is we are encouraging the kind of pluralism, both within each discipline and also collaboration among the various disciplines, but it just needs to be spelled out, so that people don't get caught up in turf wars, so that we are honoring each person's training and each person's ability to do this, and at the same time we are saying and it is good for you to get to know each other, as well, as get to know how people with different kinds of training are working.

DR. PIZZORNO: It sounds good.

Tom, and then George.

MS. CHANG: Joe, we are at the 10-minute mark.

MR. CHAPPELL: I am wondering if dealing with this at all doesn't dilute the imperative aspect of the first two, and maybe we shouldn't have this in here at all.

I am concerned about having a report that uses words "encourage." I mean I have seen so many executive reports that use "encourage," and there is no substance to it. So, I look at that and say, well, I don't feel like encouraging that today.

So, I am just feeling that deciding what we don't say at all is important in this process right now, and I don't feel this needs to be covered, that it couldn't have been covered additionally perhaps in the first piece as a support statement.

I know, Joe, that you feel strongly about this, and I don't want to diminish the value of it, but I don't want to diminish the value of the real --

DR. PIZZORNO: Thank you, Tom. I will respond to that in a second.

Joe.

DR. FINS: I think there is a real difference here, Tom. I think if we can foster this collaboration and have young residents working together, getting to know each other, working in each other's context in a non-threatening, encouraged way, it will build a whole new generation of people who know how to talk to each other.

DR. PIZZORNO: So, I guess the directions to staff, request of staff is to -- George.

DR. BERNIER: I think actually the verb "foster" would be a very good one, because that does mean

a lot of different things.

DR. PIZZORNO: Charlotte.

SISTER KERR: I just have a comment. It is my perception, just a little offering, may be rejected, I have a little concern about our consciousness to avoid land mines and are living out of fear in what we choose to say, and it is starting to feel a little bit like scaredy-cats.

DR. PIZZORNO: Hear, hear. Ming, did you want to say something?

DR. TIAN: Yes.

DR. PIZZORNO: Please.

DR. TIAN: I have a question. You mentioned cross-training or education. Well, I can understand a physician wanting to learn acupuncture, will be easy to take 200 or 300 hours, and will understand acupuncture, but the physician is not telling everybody he is an acupuncturist, still a physician, correct? All right.

Then, the other way, even the acupuncturist does not have enough Western training, but he is very good, experienced acupuncturist, what kind of program to do the cross-training or education? How could you send

him to a medical school to learn the courses? I will say that is only sharing information, and we should encourage this kind of exchange to learn each other, but it is not like a course. I will say it is not a formal course, it is going to be difficult.

For instance, he could be or she could be a very good healer, very powerful. You are going to teach him anatomy, pathology? You can mention that, okay, I treat arthritis in this way, you can mention that. That is not medical training.

So, I am a little bit confused. Can we use some better wording to more clarify that, because if you encourage too much, then, it is going to mix. The apple juice is apple juice, oranges is oranges. We need the specialties. It is very confusing.

DR. PIZZORNO: I think you have brought up a very good point, and that is our intent is not to use cross-training as a way of training the person in the other person's therapeutic modalities.

The idea is exposure on how they practice to better understand they can practice collaboratively together, but not expecting one to learn the other.

I think you brought up a lot of important issues about how to make that a valuable experience, so, for example, everybody is going it different, well, one way we do it is we send both a licensed practitioner and the student into medical clinic, and they then practice their natural medicine, acupuncture, naturopathic medicine, as the case may be, in that clinical setting, but they are side by side with conventional doctors, with medical students getting their training.

So, they are understanding each other better, but they are not in any way expecting to be able to practice the other person's skilled modalities.

So, we have to wrap this up. I think there is a high level of consensus here that we need to do the cross-training. The issue is make sure we explain why we are doing that more effectively.

So, I think the staff, you have heard a lot from us about how to do that. That is, this is about help within practice collaboratively, not cross-training in each other's modalities, and we will leave it at that.

So, now I turn the gavel over to you, Jim.

DR. GORDON: I might just add to that last part