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**Draft Interim Report**

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Volume II

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Tuesday, July 3, 2001

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# C O N T E N T S

# P R O C E E D I N G S

[8:09 a.m.]

DR. GORDON: We are going to get started this morning. If we could, just again, sit quietly together for a moment and relax, and be present with ourselves and with each other.

[Moment of silence observed.]

## Opening Remarks

DR. GORDON: Okay, everybody. This morning and today, our task is really to try to understand some of the issues that are remaining in terms of delivery of services and reimbursement, and issues related to research, and then development of the Interim Report.

As part of that work, there is a general sense that I have heard from a number of people, both in the meetings, and informally outside the meetings, that we need to deepen our common experience of our world view of our perspective of ourselves and of our connection to CAM, especially as we move into making recommendations and creating a tone and a feeling and a perspective for the Interim Report. In line with that, Tom Chappell came up with a suggestion for working on this morning's program.

Tom, I would like to give the floor to you.

MR. CHAPPELL: Thank you, Jim.

To elaborate, there are a number of us who have wanted to do this homework and we haven't had the time. So, in a brief workshop design this morning, which we planned out with some facilitators, in small groups of six Commissioners per group, we will have a chance, in an hour, or hour and 15 minutes, to get down on paper what it is we deeply care about in the consideration of CAM products and services, or the whole orientation of CAM.

We could call these our core values. We could call this who we are, but it will, as Jim said, provide a context of our common experience as we come from different perspectives, different professions, different ways of thinking about how CAM can help the world.

So the question will be simple in the small group. It will be one question. We would ask each of the Commissioners to participate fully. There will be some prioritization, light prioritization, of your responses, and we will come back into full group and share what each of the three groups has come up with, and then turn that material over to the team and the staff for inclusion and

drafting in the Final Report.

Yes.

DR. GORDON: I just wanted to check and see if the Commissioners feel this is a good exercise and an important one to do, just check in with everybody and get a consensus on this, and I am seeing a lot of nodding heads. So I would like to proceed, then, with this.

As Tom says, it has been something that we have worked with some earlier, but clearly, we need to keep on working and deepening our experience of why we are here and what we are about.

So please continue, Tom.

MR. CHAPPELL: We will just go around. There will be three facilitators: Wayne, Charlotte, and myself. I will work with a group in this room, Charlotte and Wayne will be across the way in two small groups. There will be newsprint for each group, a scribe for each group, and we will simply answer the question: In considering CAM products and services, we believe deeply that.

It has to be presented as a "we believe" because you have to have a sense of our brothers and sisters in this circle, yet, owning what it is you deeply believe in,

and respecting what your Commissioners also deeply believe in.

Out of this, we will get a set of values, a complexity of values that we will try to own and hold as we go forward into the strategy, the goals and everything else that we do. So this will be the grounding.

So if we could go around the room, Commissioners only, responding to the count. I will be one, you are two.

Okay. Would the ones join me?

DR. GORDON: Let's do a timetable on this, first of all.

MR. CHAPPELL: Forty-five minutes in the group. We will see you back here in --

DR. GORDON: Each group will be 45 minutes, and then come back to this room within five minutes after that, please. Then what we are going to do is, we will rearrange the schedule some, or we will shorten the schedule.

Our belief is that if we clarify some of these issues, our work, particularly in the area of -- I want to make this clear, we are going to be covering all the

topics: reimbursement, delivery of services, any topics remaining from research, wellness, as well as the Interim Report. The idea is, we will be able to cut down the time, particularly, we hope, the time we spend on the Interim Report, by clarifying core values.

So that is the purpose of this. We will get to everything, and there will be time for all the work that we are doing. So 45 minutes in the group, a 5-minute break after that, and then please come back in here right after that so we can begin with the discussion of the presentations from the group, and then moving into the rest of the program.

Members of the public are welcome to sit in and observe as we have these groups. All aspects of this meeting are open, so please feel free to do that in either of the groups in the next room or to stay in this room.

[Small group discussions convened.]

DR. GORDON: Okay, we will hear from each of the groups, then if there are other comments around the table, briefly give people a chance to talk.

Do you want to talk before that, Dean, or do you want to talk after that?

DR. ORNISH: I just want to say a couple words, that, having spent most of my professional life fighting for the kind of values that I think most of us share, I found myself yesterday in this kind of curious position of being the identifier of red flags, almost like the school marm, and that is not a role I am particularly comfortable in.

I think, out of a shared desire not to make a report that is boring, but rather to make an Interim Report that is going to not get shot out of the water, to try to be skillful about it. It may be that I have just been sensitized in the seven years of dealing with Medicare, trying to get them to pay for our program, that I have a real good idea of the kinds of red flags, certainly that I have dealt with. It is out of that loving, conscious desire to try to come up with a report that really ultimately makes a difference in the lives of people.

I think we can talk about our values as we have done this morning, which I thought was incredibly useful, without pushing people's buttons. I think that is different than pushing people's buttons in the kinds of

ways that we were talking about yesterday.

So I just want to make it clear that we are not, certainly Tom and I and others, are not on opposite sides. I think we have the same shared values. It is just a question of strategy.

DR. GORDON: Thank you, Dean.

Let's move, then, with each of the group leaders, in turn, talking about the experience and the beliefs.

**Presentation: Small Group No. 1**

MR. CHAPPELL: We believe deeply that CAM is an important and an essential part of health care; Number 2, for wellness, that it is an important and essential part for wellness; Number 3, that CAM has scientific validity and needs strengthening of evidence; Number 4, requires universal health education starting at kindergarten; Number 5, greater awareness and knowledge of CAM by medical practitioners so that they can refer appropriately.

So we need to provide greater awareness and knowledge for medical practitioners so that they can refer appropriately. That is as opposed to trying to bring

medical practitioners, conventional medical practitioners, up to some degree status of CAM services.

Number 6, CAM is both transforming and re-orienting the entire health care system, that CAM brings an awareness of the uniqueness of each person. It brings a new world view to health, wellness, prevention, and that is largely through an awareness of self-care. We need to use other methods, as needed, to healing self, and that illness is, in fact, a journey that has its benefits of creating self awareness and mutual understanding.

Number 7, CAM optimizes lifestyle systems and living, all aspects of life. It brings to light all aspects of our living and our lifestyles, that optimal health encompasses all aspects of living, not just self-healing but also the disease of living. CAM offers approaches to higher, more holistic and fuller life of persons and societies.

Number 8, it offers ways to answer the question, who am I; why am I here. CAM is holistic. It is a life system within a context of living. Number 10, we Commissioners believe deeply in healing of all approaches, which includes CAM, allopathic medicine, spirituality, et

al. We have a deep belief in the integration of all these different approaches. We have a deep belief in science and the scientific method. CAM is one of the many approaches to health, wellness and lifestyles, to which all aspire.

Number 13, CAM can make valuable contributions to health care, particularly the vulnerable populations. CAM is value-added, complementary, not alternative. It is an evolving, moving, dynamic model of encompassing diversity of disciplines. It has much to contribute to health care and medicine. It is inclusive of many different disciplines, all of which may and can have their respective leaders of teams. It is accountable for safety. CAM products and services are accountable for safety and efficacy.

CAM needs objective, inclusive overview of origin and evolution in the context of our culture and societal history. We need to minimize impediments to access and delivery. We need to demonstrate cost-effectiveness.

DR. GORDON: Would anyone else in the group like to say anything at this point, before we go on to the next

group? These are a statement of beliefs, each articulated by different people in the group.

[No response.]

DR. GORDON: Okay. Let's go on to the next group.

**Presentation: Small Group No. 2**

DR. JONAS: We not only laid out some core values and prioritized them, we also color-coded them for easy communication.

One of the questions that came up in the middle of the conversation, but proved to be, I think, a core issue is, what are we advocates for; what do we want to see; what is this Commission really for; is it promoting something.

I think we agreed that it was promoting something, and what we decided it was promoting, it was written in red here as the overarching goal of the , which is to develop policies or recommendations for improved health of Americans by assuring the availability of safe and efficacious CAM services and products.

So the goal is not on an advocacy for any CAM services or products, it is an advocacy for improved

health using safe and efficacious, as have been described and determined of these areas, these particular areas.

So that, we felt, was the overarching of what we want to see happen out of this Commission.

Now, what are the core values that go into providing that? I think we came up with really four main ones, actually seven, but four core ones. Those are in blue. The first one basically is a recognition that healing, self-healing, is the core aspect of what we want these services and products to provide and produce.

So the wording, we could play around with, but basically there is a remarkable capacity for healing that can be facilitated by addressing the underlying causes or by using services and practices that stimulate and support those healing processes. So an emphasis on healing is a core issue.

The second emphasis is holism. We think that what we really value in these types of practices is the emphasis on the whole person, the mind/body/spirit, and addressing that. You will see in some of the subsequent ones how we are addressing that.

Number three is really the issue of freedom of

choice, that individuals should have freedom of choice among practitioners, products and services, provided there is accountability along with that. There has to be accountability along with that.

We debated whether we should split these up into two different areas and decided no, that they really were linked, and they should stay together.

Four was that this is a consumer-driven process and we need to pay attention to why the consumers are seeking these things, and we need to let the consumers be integrally involved in that process, and this occurs on several levels, as is outlined in the , certainly in terms of freedom of choice of particular things that they would like to have in terms of products and services, but also in terms of how the health care delivery system executes those and how research is conducted on those.

So, in other words, also on policy levels, not just on individual health care. The consumer needs to be more involved in policy decisions about the health care system and research.

The ones in green were ones that came up afterwards. They support, I think, many of these core

ones, that how various services are delivered is extremely important. There should be a keen context for the provision of health care.

Those are kind of the terms that we came up with, and that incorporates things like respect, dignity, trust and core values in how health care is delivered, and an emphasis on, my term was gentleness, gentle types of intervention, but we basically translated it into less toxic and the least invasive alternatives that are safe and efficacious. End of story.

[Applause.]

DR. GORDON: Great. Thank you, Wayne.

Any other comments from that group at this point?

[No response.]

DR. GORDON: Okay. Third group, please.

**Presentation: Small Group No. 3**

SISTER KERR: Let me know if you can hear me, because my voice may be a little softer.

Number three was the honorable group of Tieraona, Buford, Veronica, Xiaoming, Linnea. Corinne was our humble scribe. Thank you.

We spoke specifically and dominantly out of the belief and value statements. First, was that we believe the body/mind has the right and power to heal itself.

The second, is we believe health is more than the absence of disease. It is the active integration of spiritual, emotional, social, physical, and I personally included ecological self.

The third, was healing is being in right relationship with self, others, community and the cosmos.

Four, we believe people want to be cared for, to be heard, to be able to choose, have better care and access to health care services.

We believe there is no exclusive domain for healing. Healing is not the exclusive domain of complementary and alternative medicine.

We believe partnership is integral to the process of healing.

We believe all human beings have a right to feel cared for and to have access to their practitioners and modalities of choice.

We believe in the value of relationships that are marked by respectful recognition of the practitioner's

skills.

We wanted to put a little footnote of particular concern, that people sometimes often use holism to cover up non-thoughtful, unsystematic health care practices.

Thank you.

DR. GORDON: Thank you.

[Applause.]

DR. GORDON: We can have some discussion. I want to say how useful, Tom, how much I appreciate your spearheading this process, and that of everybody who is participating in it.

It feels to me like what we put up on the board are really the shaping principles which will frame the Interim Report, and frame what we are doing as we move toward the Final Report, and that what we have done is to supply the impetus, the reason, in a sense, the reason why we are here, as well as the context for any specific recommendations that we are going to make. So I think it is great.

MR. CHAPPELL: I want to thank Tieraona and Charlotte and Wayne for their help with all of this, and the inspiration for it.

DR. GORDON: So, any other comments about either this process or issues that are sort of here at this point? We can come back to this, of course, as we discuss the Interim Report, but if there are issues that come up now, we can also talk about them. Any other concerns that are not articulated here that we need to discuss right now?

Wayne?

DR. JONAS: One of the motivations for doing this was to come up with a consensus. I mean, come up with at least the core issues, and I am just wondering if we need to do that at this point. We split up for a variety of reasons, but it really has to be from the whole group. I am wondering if there is a process for doing that, or, if we should do that at this point.

DR. ORNISH: I guess, for me, the question is, how much of this is implicit, that is, the subtext for the recommendations, and how much of it actually becomes recommendations, or is explicitly stated in the report.

I am not taking a position, I am just raising the question.

DR. GORDON: I think that is a question, and the

process issue is whether we want to address that now or as we move through the report. That is the first question on the table here. We will have time as we talk about the report.

For me, much of this is the introduction and the context. Some of it is definitely going to influence some of the recommendations as well, and I think that what, exactly where, and how, is going to be subject to discussion among us all.

Joe?

DR. FINS: At the risk of opening up Pandora's box here, I think this was incredibly helpful, and I thank all the people that were behind it. I think that this was essential for us to make the diagnosis before we prescribe the treatment. I feel we have written the treatment, we have written the prescription in the report here, and we haven't made the diagnosis. This is the diagnostic, and everything else should follow from this.

I think there are lots of things that are implicit here that are not explicit in the Interim Report, and I was just wondering if it would be possible for us to delay the Interim Report, which I understand is not

statutorily required, and to have an opportunity to have more ownership of the Commission in the actual Interim Report, which is so important.

It is our introduction to other policymakers, and I am just wondering, what is the basis for the deadline, and is it compelling? Because I think it is more important to do it right than to do it quickly, and I think that this is the formation of the consensus.

I think most of us could sign on to most of what is on this board, but some of us would have a hard time in agreeing on the particulars and the nitty-gritty that is in the Interim Report because of balance and tone. I just put that out for your consideration.

MR. CHAPPELL: Methodologically, this is the starting point, these are your beliefs, and then your actions arise out of those beliefs. So you have got a harmonization of internal and external, and that is where the integrity comes from.

So the first thing I want to respond to in terms of method is, this is the grounding, and then all of the recommendations and actions flow out of that. These are not recommendations, these are beliefs, and they need to

be presented.

Secondly, I just want to say that I have done a lot of this, and I know that there is enough trust in this group and enough similarity of content that I believe that Jim and the staff can scribe very close to some common points of interest here, and so I am not feeling that we need a heavy editing process, either today or later.

I think there is enough intuition, and if we have an editing committee that Jim wanted to appoint, I think we could come up with that product. What we need is a product, and it is called a statement of beliefs, but I don't think we need more time to do it.

DR. GROFT: Last July 14th, at that meeting, a request was made to the Commission that we have an Interim Report. I think we were nine months late getting started from when the Commission was not officially established by the Executive Order, but cast into the Appropriations bill.

At that point in time, the request was made by then-Secretary Shalala that we have an Interim Report available a year from the meeting dates, and we took that to be July 15th of this year.

I must admit there is no urgent request for this report to be submitted on that date. However, I think in all reality, if you want things to happen in this fiscal or next fiscal year with any thought of appropriations coming to any of the tasks that you identify, this cannot be delayed more than two weeks. Anything beyond that, I think we are starting to look at late August, early September.

The appropriations committees will be getting back together and they will be looking at this. We will have had time to meet with the caucuses, as we have been asked when we would be available to supply them with information about the Commission's recommendations and directions.

So I think, realistically, a delay longer than two weeks, we are starting to jeopardize whatever might be done in the next fiscal year's budget, not that it cannot be done in September, but I think people need time to look at what you are suggesting and to analyze it from their perspective, both administratively and legislatively.

DR. GORDON: One thing that occurs to me. I do not think it would be a disaster to make it somewhat

later, I would agree with Steve, but not too much later. We have said we are going to have a report, and I hate for us not to do what we say we are going to do. If we say we are going to have something by July, I think one of the things that we need to stand on is our integrity. If we say we are going to do something, let's do it.

And so, that is why I think, as Steve is saying, a couple weeks' delay will not change the appropriations process, but we have said to the Secretary, we have said to Congress, we have said to Senator Harkin, we will have the report by then, and I don't like to back off that.

DR. ORNISH: What are we going to do with the extra two weeks, anyway? It is not like we are going to be meeting, so how would we use the time even if we did that?

DR. GORDON: What I would like to do, what I would like to suggest, is that we spend the time that we need now going over the report. Personally, as somebody who has participated in writing the draft and participated in this process, I feel like this process is very much informing the draft. I think the draft spent too much time looking at some of the specifics.

I think Joe's analysis is not unfair, that there wasn't enough of a diagnostic and descriptive process at the beginning. I think we can easily incorporate that, because these are the shared values that should shape what we recommend.

The idea of the process is to do as much as we can today and then get it back, to have an agreement, first of all, an agreement about tone, an agreement about context, and an agreement about recommendations, and if there are words that are buzz words, to deal with those and eliminate those, and to bring in the kind of language that we want, and then to send it back to everybody and get input.

If we find that there is substantial disagreement and concern, we can go through the whole process again and put it off. I would like to shoot for that date of the 16th.

Yes, Wayne?

DR. JONAS: I think since there is a date we have to have some kind of report, and there is flexibility in terms of what actually goes into that report, that the time we have is right now, and we don't have any other

time. I think we need to clarify these issues. I am not sure we have had enough discussion of these issues so that we as an entire group can come up with at least a few fundamental consensus items that should go into that.

And then, I think we should go right into the report and start discussing it so that we can actually see what are we going to produce, and then we can circulate something around that we have all had at least some time to start with.

DR. GORDON: Yes, Charlotte?

SISTER KERR: I just want to say that I agree with what has been said, and I feel that the statements, the philosophical underpinning statements or vision statements are calls to attention. They are requests for listening, and they are the energetic needle put into the Congress for the listening and the focus. It is absolutely mandatory we get clear on it, that we have our process of diagnosis right before we make any prescriptions, plans or evaluations.

Thank you.

DR. GORDON: You're welcome.

Bill?

DR. FAIR: Well, this may be accused of being a surgical approach, but I think we ought to go ahead. I mean as Steve articulated very well the reasons for doing so, I think we would damage our credibility if we didn't, and there will never be 100 percent agreement on it, no matter what we do. And I would just like to close with a comment, one of my favorites, from Sir Winston Churchill: "Action based on perfection is paralysis." I think we can't afford that.

DR. LOW DOG: Well, this is an interesting process, but if we don't conclude it, that is all it was, was an interesting process. So I think that there has not been closure yet on this, and I don't think we want to have 50 beliefs, that many of them are overlapping.

I think we need to have just a few, and we need to go through now. We can do it quickly, but I think we need to go and try to get some consensus on a few of them while we are all still here, because I think what the Interim Report must have is, it must have the core beliefs or goals of this group that feeds through the entire Interim Report, and go, then, to the report.

DR. GORDON: Okay. Other comments?

[No response.]

DR. GORDON: Okay, is there a general consensus that the group as a whole would like to go through these beliefs, and to select out the core beliefs that will animate the entire Interim Report and shape our deliberations? Yes? Do we have a consensus on that?

DR. JONAS: Provided we go then to the report directly, and we have a timeline for it.

DR. GORDON: Okay. Well, let me provide -- Wayne, I'm sorry?

DR. JONAS: Provided we have a timeline for the report.

DR. GORDON: Okay. Let me just say something related to that.

DR. ORNISH: Some of these are not values, some of these are actually recommendations, like requiring universal health education. I think we need to be careful about separating those.

DR. GORDON: Okay. Let me just make a point. If we are going to do what Wayne, in particular, is suggesting, and what others seem to agree to, we are not going to have time to go into some of the other issues

that we have, or we may not have time.

Does everybody understand that we are not going to be able to go into the kind of detail with reimbursement, access and delivery, and wellness and self-care that we have with the other subjects, although we will address them in the context of going over the Interim Report?

I just want everybody to understand that we are making a choice, and that is a perfectly good choice, but we are making a choice.

DR. FINS: And I think it is legitimate, because people make value statements that will guide that and will make that easier downstream.

DR. GORDON: Okay. Everybody okay with this process? Tom?

MR. CHAPPELL: I just wanted to see if I have clarity about the next steps here. Are you suggesting that 18 of us deal with 30 beliefs on an open team?

There are some designs that would work. If you want prioritization, for instance, there is a tool I can offer of how we could arrive at greater prioritization.

DR. GORDON: What I first want to get is

agreement that this is what we need to do, and then we can talk about the specific tools that we are using.

Is that the agreement, consensus?

[No response.]

DR. GORDON: Okay. So then, what we are going to be doing is we are going to go through the beliefs. I think Dean's distinction is important, the difference between beliefs and recommendations. What we want to focus on is core beliefs and values that will animate the report and will be included in the language of the report, in the introduction, and will also be part of the body of the report at appropriate places.

Then we will move into a discussion of the elements of the report in order.

Yes, Tom?

MR. CHAPPELL: It is important not to discard something that looks like an action, but to restate it as a belief, because there is a belief substance in every actionable statement.

DR. GORDON: Okay. Duly noted.

Joe?

DR. PIZZORNO: I have a two-process

recommendation. One is, I think we should, before we do this, put on the vote here a timetable for the rest of the day so we are clear about how we are allocating time. And second, is a process that we have used for this kind of activity, is, give everybody five little stickies and you put it on the ones you think are most important, and immediately it pops out where the commonality is.

We may not have any of those little stickies, but maybe we could take a 15-minute break and staff could buy a batch and we can put them up there. Or, we could just put a mark with a pen. We can't do more than five.

DR. GORDON: Okay. Is that a process? Tom, is that --

MR. CHAPPELL: That is what I was looking at.

DR. GORDON: Okay. So I think what we should do is take -- well, Joe is suggesting doing it by balloting, but I think it may be easier to take the action. It just may work out. So you are suggesting putting five marks, each person puts five marks by the recommendation.

I think it is important, as we look at the recommendations, to remember that the process by which they were arrived at was different in the different

groups.

So, for example, in the group that Wayne was chairing, there was an attempt to get consensus about specific recommendations, and in the group that Tom was chairing, clearly each recommendation represents an opinion of one person. I am not quite sure, Charlotte, was yours a consensus?

SISTER KERR: Yes.

DR. GORDON: Yes. So there are two different methods that are being used. If what we do is put those marks up, then we will take the ones that come closest to the top, and we will begin discussing them. I think what we will also find is that a number of the recommendations from different groups are very similar among the groups.

So with all of that in mind, what I would like to suggest is that we take a 15-minute break, and that in the course of that time, everybody will have a chance to put their marks up beside the numbers, and then we will come back.

Michele?

MS. CHANG: Just a process question. Are we clear on what the mark represents? Is it, those are the

things that we are now going to discuss for what purpose? Are we discussing them as recommendations, or as what?

DR. GORDON: Let me just make clear that what we are going to be discussing are core beliefs and values.

Is that correct, everybody, at this point? William?

These are core beliefs and values. These are not recommendations.

DR. ORNISH: I am a little uncomfortable. I just want to raise this as a question, and you all can shoot it down.

There are two different approaches here. One is that we get clear about what our core values are, so that we can then use that as a context, as I mentioned earlier, for our recommendations. The other is, is the intention of this, what we are about to do, to decide which of these core values that are actually to go in the Interim Report?

I just want to raise the awareness that there is a risk of doing that. There is, on the one hand, an opportunity to do that, but there is also a risk that if you have core values that are very different from other people's core values and they end up in the Interim

Report, then they become red flags for people.

We may say, well, that is just too bad; that is just the way it is and we don't care, but I think we need to go into that with our eyes open and make a real choice about that.

DR. LOW DOG: I think the point, though, is that we are trying to do consensus, and there is a very diverse group of people here. As long as they are true to themselves about what they believe, because if we don't have consensus, it won't go in.

So I think everybody just needs to be real true to themselves and put up there what they can live with. When we come to consensus, I think if we can all agree, then I think that there are not going to be big land mines.

DR. ORNISH: But that is where I am trying to make a different point, which is that we can all agree on something and it can still be a land mine. That's all. I think that that is okay as long as we are clear about that, but just because we agree on something doesn't mean that it is not going to push people's buttons.

MR. CHAPPELL: I think the cost of perhaps

disenfranchising a couple of core beliefs that don't make a hit list can be avoided by our agreeing that we are not going to have 30 beliefs. We want to have this list around eight to 10 beliefs, and there are lots of common threads in here.

So I think if we were to go for more than five, I am thinking seven, we will be less disenfranchising.

DR. PIZZORNO: All right, seven.

DR. GORDON: Any other comments on this?

MR. CHAPPELL: Seven is a CAM number. I mean, it is spiritual, it is traditional.

DR. GORDON: I know. This is exciting.

What I would like to do is to give us the chance to see what the leaders are in these beliefs, and then we can talk about them. My sense is that they are going to be incorporated in different ways, that ones for which there is full and enthusiastic consensus will be stated very much up front as core beliefs. Others may influence some of the tone and some of the recommendations.

We will have an opportunity to discuss possible land mines, and we will have an opportunity to discuss exactly how many numbers, land mines, or fireworks, gold

mines. Thank you.

Joe? Go ahead. We have a couple more comments.

DR. PIZZORNO: One more small detail, just to make it easier. If we stick some crosses, just put a line down. If you see four, put a cross; make it real easy for people to count afterwards.

DR. GORDON: Effie?

DR. CHOW: I am concerned about the repetitions, the duplications. There are a lot of things there. If you select five, does that mean all the others go out, or will there be a process where you take the rest and kind of integrate it?

DR. GORDON: What we will attempt to do, what all of us will attempt to do collectively, is to take a look and see what we have done, once we have done it, and then we will try to integrate. We may not have the exact wording of each statement, but we will have the basic principle there. If there are a couple, or three or four, that are very similar, we will try to work them together. Okay?

So I think we need to see how it falls out before we move any further. So let's take a 15-minute

break and do this process.

[Recess.]

**Discussion Session IV: Core Beliefs**

DR. GORDON: Okay. Before we begin the discussion of the tally, what I have done is, I have tried to group some of the responses that are similar with one another. So we will go through the ones that have the most assent from the group, but before we begin, Linnea wanted to read a poem that will help us get centered. It was a poem she was going to read before she led her session on access and delivery, but it is a good time to read it now, too.

MS. LARSON: I thought that this would enable us somehow to get focused, and it is from a book of poems by a poet named David Whyte, and the book is titled "The House of Belonging," and the poem's title is called "Working Together."

> "We shape ourself to fit this world, and by the world are shaped again, the visible and the invisible working together in common cause to produce the miraculous. I am thinking of the way the intangible air casts its speed 'round a

shaped wing, easily holds our weight. So may we in this life trust to those elements we have yet to see or imagine, and look for the true shape of our own self by forming it well to the great intangibles around us."

DR. GORDON: Thank you very much. Very apropos.

What I have tried to do here is to tally the marks, and then to group according to similarities. What is interesting is that there are a number of similarities.

Does anyone know where Wayne is? It would be good to have him here.

COMMISSIONER: He is on the phone.

SISTER KERR: I will go get him.

DR. GORDON: Why don't you get him.

The first statement, which is a kind of restatement of the mandate for the Commission, is this one here and is the one with the single most number of marks besides it: "The Commission is for the improved health of Americans by ensuring the availability of safe and efficacious CAM services and products." So this is the one to which there is the most general assent.

Second, is this one here: "Individuals should

have freedom of choice among practitioners with accountability." This one is not directly stated anywhere else, but it is echoed in some of the others here. For example: We believe in healing, of all approaches; CAM is has been evolving and moving to dynamic models; a diversity of disciplines; We need to minimize impediments to access and delivery.

So all of these have some relationship to this one here. Let me repeat that one: "Individuals should have freedom of choice among practitioners with accountability." Then there are a variety of others that come under this.

DR. FINS: I think it is really important that we don't editorialize and spin it. I mean, I can see differences. I think people who voted for that may not endorse that.

DR. GORDON: Understood. Understood. I am just saying that there are others that have been put up that may be similar, although this is the primary one. Okay?

SISTER KERR: Just also to say, the second part of the one that has a lot of -- is similar to that one.

DR. GORDON: I'm sorry. This is the same one.

Thank you, Charlotte. This is the same one as Number 1, really.

SISTER KERR: Number 2.

DR. GORDON: Number 2, sorry. This one here: "All human beings have a right to be cared for and to have access to their practitioners and modalities of choice." What we are looking for is a general feeling.

Would you agree that that is pretty much the same as Number 2?

SISTER KERR: Yes.

DR. GORDON: What we are looking for is the general feeling. Joe, I appreciate what you said, but I am trying to give a sense that these may have something to do with that, but they may not be as clearly marked up.

Number 3: "The body has a remarkable capacity for healing that can be facilitated by addressing underlying causes of illness and suffering."

This one here: "The body and mind have the right and power to heal themselves." This one is Number 4. Maybe it's Number 3 in terms of the tally.

DR. LOW DOG: Oh, I see. I wanted to clear how you are going through it.

DR. GORDON: What I'm trying to do is, and it may be one or two more, but these are definitely the ones that are the leaders. This one is health is: "Health is more than the absence of disease, it is the active integration of spiritual, emotional, social, physical and ecological selves." That is Number 4.

"CAM is holistic, a life system within a context of living." That may be a slightly different way of stating it. And over here: "Emphasis of care of the whole person, mind, body and spirit." In fact, I think you are right, this one is actually Number 3 in terms of tallies, since we put them together, rather than Number 4.

Number 5: "It is consumer-driven health care, and consumers need to be involved at all aspects, from personal to policy levels of health care."

Number 6: "Has scientific validity and needs strengthening of evidence."

MR. CHAPPELL: In the group, it was presented as a belief, that there is a lot of scientific validity, but we need to have better substantiation through more evidence.

DR. JONAS: Is that a belief and a commitment to

science, then, as a process for identifying safe and efficacious?

MR. CHAPPELL: Yes, and that shows up in some other statements about our commitment to science and the scientific method.

DR. GORDON: Let's speak one at a time into the mike so we can get the discussion down.

Wayne, you asked a question?

DR. JONAS: Well, there is a difference between saying we believe there is science to support CAM, than from what I think I hear you saying, which is that we believe that science is an important process for clarifying what is safe and efficacious in complementary medicine.

In other words, there is a commitment, a belief to science and the scientific process.

MR. CHAPPELL: Totally. So said in our group.

DR. FINS: I mean, that raises just a process question, whether or not if that is something that other people would have endorsed and they didn't see up there in a clear way. I was sort of surprised that concern for the scientific method and scientific validation only got five,

eight votes, or whatever votes, because I think that if I do my own head count, there are more people who believe in that, but Wayne might not have voted for that, for example.

DR. JONAS: Actually, no. I am also surprised that that is lower.

DR. FINS: I mean, can we just ask --

MR. CHAPPELL: Well, that particular point is fractionated. It shows up in more than one, so if you pool the ones on that subject, you will get a bigger number.

DR. FINS: I think this is an important enough point for the people in conventional medicine that I would just like to posit some language, maybe, that, Wayne, you just offered.

You want to just restate that, and maybe we can just take a hand count to see if people see that as more belief?

MR. DeVRIES: Let me throw out, for example, what I did. I agreed with that statement, however, I thought this statement right here, that this group made as an overall, said the same thing, that it was a broader

statement. I thought it was an outstanding statement, and that is why I went there. I didn't give a vote to that, because I believe that really replaced it, and then some.

DR. FINS: I voted for that as well because I think it is very encompassing and it is a broad thematic. But again, because I think we want to avoid land mines and we want to have a balanced sounding report, I would like to offer to the Commission Wayne's language, if you could recast it, and then just take a hand vote, just to say that it is one of the major beliefs. We are asking for six votes.

I know it changes the rules a little bit, but I think it is something that got embedded --

DR. GORDON: Well, I think each of these is what our core principles and values are, and we are not going to put them in a hierarchy of the report, but I think your request is an absolutely legitimate one.

Joe's concern is to get us on record as a commission stating the importance of scientific investigation.

DR. LOW DOG: Right, because I think for me, when I saw CAM has scientific validity, I couldn't sign on

to that because some of them really do not. So it limited me from choosing that, though I believe very strongly in the role of science here.

DR. FINS: Did you just offer that?

DR. JONAS: We may not put all our five in a particular hierarchy, this is more important than this, but we are going to have a cut-off at some point. We are not going to do 30, and I certainly think that commitment to science and the scientific process should be on our list, definitely. We should have that explicit as one of the core issues that we are committed to and just state it that way.

DR. GORDON: Wayne, do you want to state it?

DR. JONAS: Yes. That we are committed to science and the scientific process as a method for identifying safe and efficacious CAM therapies.

DR. FINS: All in favor?

[Show of hands.]

DR. FINS: Anybody opposed?

[No response.]

DR. FINS: No.

DR. JONAS: Well, we are committed to science

and the scientific process for the identification and development -- is that the adjective -- of safe and efficacious CAM therapies, yes, and services and products. Okay, services and products.

DR. PIZZORNO: I think we should include terms like "effective and appropriate." I think the reason for that is because, I know within much of the CAM community there is an anti-science perspective, a belief that science kind of takes the magic out of the healing, and I think we should be very clear that we don't agree with that. Science is an appropriate way of advancing these modalities and therapies.

DR. FINS: You want to just read it so Michele can just get the definitive words?

DR. JONAS: Well, I just said we are committed to science and the scientific process for identifying and developing safe and efficacious, and you can add "appropriate" if you want, although I think that is a little more complicated than actual science.

DR. GORDON: Well, "appropriate" may come before the "science," appropriate use of scientific methods.

DR. JONAS: Science and scientific process for

identification and development of appropriate CAM products and services.

DR. FINS: Yes, because that means that science is appropriate when it is convenient, when it fits an advocacy position. That is not what we mean to say right here.

DR. JONAS: Yes. I think identifying appropriateness is a much different process. It uses science, but science itself is primarily for identification and development, and finding and developing safe and effective services and products, and whether appropriate or not, is more complicated than that.

DR. GORDON: [Inaudible] -- requires universal education starting in kindergarten. The other is a greater awareness and knowledge of CAM by medical practitioners so they refer appropriately. Where are we with that?

DR. JONAS: I don't see those as core values. I see those as ways of applying some of what we have just talked about, so those may go into the actual recommendations, and they are actually in the recommendations.

DR. GORDON: Well, let's talk about these, and then I have one other point I want to raise.

MR. CHAPPELL: Has the point of education been made yet in any of our other core values?

DR. GORDON: No.

MR. CHAPPELL: So we don't want to discard this because it sounds like an action. We want to rewrite it so it is a core value on education.

DR. GORDON: Well, I think it is there implicitly. We might want to rewrite it in terms of we place a value on education and self-awareness, something like that.

MR. DeVRIES: If you changed consumer-driven health care, personal and policy, and in parentheses said research, education and delivery, would that get you there? It is on the third sheet from the left, second one, consumer-driven health care, personal and policy, research, education and delivery.

MR. CHAPPELL: George, the difference for me is --

[Interruption.]

MR. DeVRIES: Just a broad area that says

consumer-driven health care, consumer-driven health care, personal and policy, so it is not just policy, it is personal and policy, and then in the context of research, education and delivery. Just a thought.

DR. GORDON: It may be important to emphasize education as a separate item, because it is a kind of balancing of treatment and teaching. It represents a different way of thinking about health care and is very much a part of CAM. It says we are not just treating people, whether it is in the context of the office or in the context of the school, or the context of a public library methods or self-awareness.

DR. FINS: I just want to go on the record that the Latin root for doctor comes from teacher. So there was something to it in conventional medicine before it became a CAM thing. I think the notion of having a collaboration with paients is important.

DR. GORDON: Okay, let's all talk one at a time so that everybody can hear.

Well, there may be one thing you want to remind people of, that this is part of the healing tradition, and that we are re-emphasizing it, and it is re-emerging once

again in CAM.

Now, there is one other issue, some of the aspects that were mentioned here that I have subsumed under Number 3, where four people marked this one having to do with emphasizing the uniqueness of each person, and I am wondering if that is something that we want to either include in what we have done, or make it a separate category. Perhaps we might make it part of Number 4, integration of body/mind/soul, and we might add "and the uniqueness of each person."

Yes, Joe?

DR. FINS: I would say that that sounds right, the definition of health. So it is not a CAM definition, again; it is more than that.

DR. GORDON: Exactly.

Go ahead, Joe.

DR. PIZZORNO: If we ever have to do things here that are only uniquely CAM, there are shared values across health disciplines, and we should have that.

DR. GORDON: Anything else on what Michele just raised, of uniqueness? Is that a value, is that a belief that each person is unique and has to be approached as a

unique individual?

Yes? Nodding heads? Okay, great.

Effie?

DR. CHOW: I just want to point out, I think that is really important because that is how the practitioners deal with each person, and also, that relates to research, and that you can't do one and it goes across the board for everybody. So I think that is important, whether you include it into that number.

You suggested putting it into that number up there, the first one?

DR. GORDON: Either we can put it into that number, or make it separate.

DR. CHOW: I would make it separate.

DR. GORDON: Separate.

DR. CHOW: Because it is such an important issue.

DR. GORDON: Other comments about that?

So what we have is, I think, about eight different statements about shared belief and values which we understand.

Joe, I don't think an attempt is going to be

made to say that it is only ours, but these are values that we have. In fact, I would like to make a statement that these are, in some sense -- the language is not quite right -- these are the enduring values of health care and healing, sort of the deepest, most enduring values of health care and healing in many different systems. So we are part of something; we are not apart from. Okay.

So we can either move ahead with looking at the Interim Report at this point, understanding that these eight are shaping values for what we are doing, and understanding that we will integrate these into the introduction and the overview as well, and then take up the body of the report, and see what we want to do with the report and how we want to have these values introduced into the body, and also, just how we want to look at everything that is in the report, and see if it makes sense to us. Or, we can spend more time discussing these. So there is a choice point right here.

Joe?

DR. FINS: There is another big theme, which, again, might have been buried in all this, which I think I did hear a consensus on in the past, and that is the issue

of integration, that if patients move from the CAM world to the conventional world, and back and forth, and it is a single patient, we need to have an integrated approach in order to ensure safety and efficacy, collaboration, referrals, the entire panoply thing.

So I don't think any of these statements capture the importance of the integrated versus the world approaches.

DR. GORDON: Joe, I think that is right. I think what we need is some kind of discussion about the wording because some people like integration, some people prefer collaboration.

DR. FINS: I am not wedded to the wording, but the idea of collaboration is something that I think we have to endorse. Otherwise, everything else we have aspired to won't be along operational lines.

DR. GORDON: Tom?

MR. CHAPPELL: Bill used some interesting language in our group about following the consumer here, and so providing collaborative services is better than force-fitting this different methodology. So I do agree with you that this needs to be addressed as one of our

core values, and I prefer the notion of collaboration to better serve our consumer.

DR. GORDON: Other comments on this? Because I think this is -- especially if there are any differences or any concerns about this issue of collaboration, integration, we should get them out on the table now and it will make our looking at the Interim Report easier.

Anything, Joe? Do you have anything? Are you okay? Yes, Tom.

MR. CHAPPELL: Again, our group, building on collaboration was more complementary, the notion of value added, but perhaps that is -- I guess I will stay with what is on the board.

DR. GORDON: Veronica?

DR. GUTIERREZ: I would like to go back a second to education. I think part of that was addressed under the issue of a partnership between the provider and the consumer, and part of that relationship or partnership of healing is education. So I wanted to factor in that partnership perspective.

DR. GORDON: Does that feel comfortable to everybody? All right.

Are we satisfied with these as stated? And can we move ahead to the Interim Report, or do we want to have more discussion? Okay. Go ahead, Joe.

DR. FINS: I mean, I think this discussion hopefully will be time-saving downstream, so I apologize for it, and I appreciate your indulgence in giving me more opportunity here.

In that first thing that we all agreed upon --

DR. GORDON: Fine, but just understanding we need to get to the nitty-gritty of the Interim Report as well.

DR. FINS: Not to nitpick with the language, but other people will. I agree wholeheartedly with the sentiment of statement Number 1 in red, from Wayne's group. The question is when we say "assuring the availability," could that be construed as an entitlement which raises all kinds of problems about other entitlements, and I am just wondering if "assuring" is the right word.

DR. GORDON: Tom?

MR. CHAPPELL: "Helping to."

DR. GORDON: "Helping."

DR. FINS: Can we leave that to Jim to wordsmith it?

DR. GORDON: Okay.

DR. FINS: Is that like a red flag in anybody else's landscape, a land mine? It begs the entitlement question. It is implicit.

DR. GORDON: Go ahead.

DR. CHOW: I like the word "assuring" because following that, you are talking only about safe and efficacious CAM, not all kinds of different things. So I would go with "assuring." That is more action, just like Tom was saying. What was it you don't like, "encouraging"?

DR. GORDON: George, please.

DR. BERNIER: Can you tell us where we are in terms of numbers of guiding principles?

DR. GORDON: We are at nine.

DR. FINS: Can we say "ensuring"? Because what we are talking about here is not an entitlement, but whatever is out there, whoever pays for it, it is safe and it is efficacious. Not that we are supplying or giving.

DR. GORDON: "Ensuring"? Okay. Anything else on this?

Yes, Tom.

MR. CHAPPELL: I think we are doing very well. Nine or 10 of these is max. We are really at a good number, and I want to resist any effort to try to come up with any overarching statement for them all because that is not where it is at. It is the particularity here of each of these nine that we are making a commitment to, and these are the gains and values that we have to incorporate now in the choices that we make going forward.

DR. FINS: Like you planned it all along, Jim.

DR. CHOW: I would like to know what the difference is to Joe, the "ensuring" versus "assuring."

DR. PIZZORNO: I think we should move on. Let's leave this wordsmithing to the staff. We have given a large input, and we could argue three or four different words there. I don't think we are going to change it.

DR. FINS: Just so the instruction to Jim would be so that it doesn't infer an entitlement that is not intended.

DR. GORDON: Okay. Are people content to move

on?

DR. JONAS: I mean, these are all over the map, still. It would be nice to have them condensed on a single piece of paper. Is it possible to have that available, say, for this afternoon as we go into the thing, and we can have them on a single -- wonderful. I don't want a summary of all the major points of yesterday and today. I only want these 10 reworded so that we can look at them, and maybe we will do a little wordsmithing on them. I think that would not be a bad idea.

DR. GORDON: I think there are two things. What Jim was saying, Wayne, is that he is also going to give us the points from yesterday because they may be helpful to us in looking at the report. So I appreciate him doing that. It is a different issue.

DR. JONAS: It is, and I would like these up on the wall. I mean, if we are going to say, all right, here is what we are going to start with, then I suggest that we take all these down, raise the 10 that we have, put them up on a couple sheets or whatever it takes, and have those there as we go into our discussion.

DR. GORDON: Fair enough. Everybody okay with

that, with having the 10, Number 10 up there?

[No response.]

DR. GORDON: Okay, good. So the revised order is to move directly into the Interim Report at this point, rather than take the more detailed look at reimbursement and access, and delivery and wellness. I just want to check in with people, and to deal with access, delivery and wellness in the context of dealing with the Interim Report, unless we have extra time, in which case we can go back to them and look at them in more detail. That is where we are right now.

I just want to make sure that everybody is content with that, including the people who are leading, facilitating the discussions, Tom and Linnea particularly.

One of the things that Tom mentioned -- and I don't know if you feel this way, Linnea, too -- are, there a couple of issues that you would like to raise for us. Or, do you want to wait until we come to that section of the report before you raise the issues? Linnea?

I am asking that because they spent a lot of time thinking through all of the issues related to these topics, and there may be some things that would be very

valuable for us to consider at this point.

MS. LARSON: Yes. I did want to emphasize the conspicuous absence of recommendations under the category of uninsured and underinsured. So I would really like us to be mindful of that, and to actually offer up some solid recommendations. I have a few, but I really want us to focus on that area.

DR. GORDON: Thank you. Tom? You have anything you want to say at this point?

MR. CHAPPELL: The self-care/wellness pieces in your book, not the Final Report, but in the book. There is a menu of many considerations, and they fall under five different categories that are expressed in the report, on page 20 of the report.

So I think if we just ask the writers to be directed at lines 9 through 17 of the report, that circumscribes the issues that need to be addressed.

DR. GORDON: Lines 9 through 17?

MR. CHAPPELL: On page 20 of the report.

DR. GORDON: Of the report, okay.

MR. CHAPPELL: Specifically teaching, promoting and encouraging CAM approaches to wellness, self-care.

DR. GORDON: Okay.

MR. CHAPPELL: Be mentioned in all levels of the educational system, integrating CAM, assuring all conventional health professionals have some training, integrating CAM into the workplace, health activities. Very important insight, and exploring ways to integrate CAM into the national health and wellness initiative of the entire population.

So from my part of the report, it is to keep the focus on those five questions.

DR. GORDON: Great, okay. We will come back to those. Those are the recommendations that have been made in the draft, so we will be coming back to those.

Now, the process of going through a report, in a group of 20 is not an easy one. I think what we need to do is to focus, or at least, what I would like to do, and throw it out as a suggestion, and I am obviously open to modifying it, is that we focus on the general areas of concern that we feel ought to be in the different sections, that we get a sense of what the tone is or is not, how you would like the tone to be, that we address any specifics that either need to be emphasized or that

are absent, or that should not be in the report, and that we focus, especially, on the recommendations that we come up with at the end.

I think that if we try to go over every word, we are going to drive ourselves crazy in the context of 20 people doing it. We can do it where it really seems important, and I am not sure about that. I am just raising that as a possibility, and I would like to now open it to discussion about how to go through the report.

My thought was to go through it section by section, and to hear people's issues, comments, concerns about content, tone, specificity, and what is left out as well what is there.

Charlotte?

SISTER KERR: My comment is not so much on process, but in light of what we just did -- for example, what arises for me, speaking of the page, was it 20, you were on? Twenty, beginning at line 9. For example, we have a lot of statements throughout our study, a report that is integrating CAM approaches into training and education in CAM approaches.

As you know, one of my concerns has always been

that we would say that this is talking about modalities being added onto a system, and what arises now for me that may be appropriate in language here is, for example, something like integrating the principles and practices of CAM, speaking of the 10 as principles. They may or may not be principles.

Do you understand what my point is? What do we actually mean, if we say "integrate CAM approaches"? We want to teach everybody about acupressure, shiatsu massage, or we want to teach them that people are dah-dah-dah-dah-dah, which we just listed?

DR. GORDON: Okay. Let me back up for a second and tell you that what we are talking about now is a general principle, in a sense, about the way we are going to approach all the issues in the report, and that is great, that is a good way to begin.

Before we go into that discussion, I want to get a sense, which I think whoever passed it, probably Michele, said. Who is leaving early?

MR. CHAPPELL: I am.

DR. GORDON: What time are you leaving?

MR. CHAPPELL: At 1:30.

DR. GORDON: 1:30, okay. What time are you leaving, George?

DR. BERNIER: 3:45.

DR. GORDON: 3:45, 4:00, okay.

So with the exception of Tom, we have everybody here through 3:30 or so.

So my concern about you, Tom, is that we make sure that we do our best to make sure you are here for the discussion on wellness, since that was the area that you were particularly concerned with. So we may need to shift the order of looking at the report a little bit to accommodate you. I would like to do that. If that is okay.

Is that okay with everybody, that we make sure we do that? And then, before everybody else leaves, we will have finished the discussion about the Interim Report. At approximately 3:30 we will be having public comment, okay? So that is the timetable. We will take a break at 12:00, 12:10 for lunch for 50 minutes. A 50-minute lunch.

**Discussion Session V: Draft Interim Report**

So let's begin. We will come back to you,

Charlotte.

Charlotte raised the issue that perhaps it sounds, in the report, too often like we are talking just about techniques, that we ought to be talking about and referring back to principles, these 10.

SISTER KERR: Principles and practices.

DR. GORDON: Principles and practices.

Yes, Tom and Joe.

MR. CHAPPELL: Yes. I think it is very important we maintain the word "beliefs," not "principles," because that is what we said we were doing, and principles and beliefs are different enough that it changes it.

DR. GORDON: Do you want to say how it is different and how it changes it?

MR. CHAPPELL: Well, a principle is something that is going to help guide joint, or guide action, it is kind of a guideline. And beliefs are a common baseline of agreement and understanding, and so I don't want to confuse substance with process. So it will work very well if we do drop in the word "beliefs," as Charlotte is suggesting, into some of the language here.

But I also wanted to comment on your question about process. For me it is really important that I have trust in you and the staff to do the writing and editing. I can't come here and negotiate and wordsmith. I don't have time for that, but I absolutely trust you and the staff to gain the sense of things and to put a draft together to the best of your ability. And I think that is the common principle we need to have in moving forward here.

DR. GORDON: Thank you, Tom. In light of that, Tom, what should we be focusing on in these discussions?

MR. CHAPPELL: How we can help you as the drafters, and being sure that you are gaining from us what we want for edits and changes. We just dump it into your basket.

DR. GORDON: Okay. Charlotte, you had something you wanted to say, and then Joe, and then Linnea.

SISTER KERR: I don't have a conclusion. I wish I had a dictionary and my Latin is not very clear, but I want to request of those who deal with this word "belief" and "principle" that we really look at exactly what we are saying.

I have a feeling "belief" to me feels like it may be one of these yellow flashing light things that some of my colleagues keep referring to, and I really want to know what the root of "principle" is myself.

DR. GORDON: Joe?

DR. FINS: I am responding to Charlotte's example, not the specific, but I think it is a very rich question, I think it is very interesting. I think it should have a home in the Final Report. I am not sure it is what we need to do in the Interim Report because this is very short, and I think what you just raised is a much more complicated question.

It would help, I think, to get clarity about what we really want to put in here. I think a little vaguer, a little less fully address these kinds of issues would I think be probably more appropriate for this juncture. And I think we can learn a sort of process lesson from this process in ramping up for the Final Report in a way that allows us to contribute and write and not to wordsmith, but just to be more collegial about how that document gets produced.

DR. GORDON: I have Linnea, Effie, and Tieraona.

MS. LARSON: This is a comment to Tom in terms of the process of the writing of the Interim Report. I would actually like the Commissioners to have the opportunity to make comments prior to the release and the printing, to use those comments, for the staff to be able to use those comments, not just simply say okay, now in 10 days you are going to write it.

I want to have all of the Commissioners who are able to, to say yes, I have read through this draft and I am going to make my comments in the next 10 hours or 12 hours. So it is processed.

DR. GORDON: The plan that we currently have is to take everything -- let me just clarify this -- to take what comes out of this meeting, the 10 principles, the 10 beliefs, to take the recommendations, the critiques, the concerns about which there is general consensus, and I want to emphasize that, and to represent those in a draft that will be prepared within six days, will be out to every Commissioner with three days, then to give back critiques as detailed as anybody wants on it.

If you want to have phone calls, that is fine, too, whatever, but the idea is we are going to try to

represent what comes out of the whole Commission, and then give it back to everybody with several days for comments, and then produce the report. Now, if we go on and send it back yet again, it is going to prolong it.

So, Linnea, does that answer it?

MS. LARSON: Yes. I wasn't interested in prolonging anything. I was simply interested in the collaborative effort with clearness of our beliefs that happen in here, and in clarity of the written word. That is what I was interested in.

DR. GORDON: Terrific. Yes. That sounds great. That is the intention all across the board.

Effie?

DR. CHOW: Whether we use the words "principles," "belief," or "conceptual framework" or whatever, this has come from the Commission for this process. But what about the belief and the principle or conceptual framework from the people, you know, that we have heard of? Is there any attempt to extract from that the concepts?

DR. GORDON: I think the question you are raising is a really important one, and it is a question

that we have had just in creating this draft, and that is, are we speaking as Commissioners who have heard others and are integrating what we have heard; are we relaying what people have said; or, are we speaking on our own.

For me -- and we all need to figure it out together -- my sense is that, ultimately, we are speaking as Commissioners who are representing what we have heard. I think one of the errors we make sometimes in the report isn't entirely resolved, because sometimes we just refer back to what people have said, and we haven't taken ownership.

Maybe it is this process of this meeting that enables us to take ownership of what we have heard, because, ultimately, we are responsible, and of course, we are responsive and responsible to the people who testified to us and to the American people.

So it is an interesting balance. I think that is one of the issues we have to discuss and come to an agreement about here.

DR. CHOW: That is exactly the point of my question, and the thing is, it can come from the Commissioners themselves and the body of people that we

have heard. I don't see it either/or.

DR. GORDON: Tieraona?

DR. LOW DOG: Yes. I just want to add to that. I think it is not only what we have heard, but what we have not heard, because I think we need to be very, very clear that we did not get a full spectrum of people here that we listened to, that represent all of America.

DR. GORDON: Tieraona, before you move on, do you want to say something about that? Because I think that is an important point.

DR. LOW DOG: I think we heard a lot of the believers. I think we heard a lot of the advocates. I think we heard from a lot of people who are invested in this moving forward who have strong beliefs, and that is not good or bad. I am not saying that. I am not placing a judgment on it. I am just very clear that if you say that 40 percent of the public uses CAM products and CAM services, it means 60 percent do not.

Many of the people who are not interested in CAM also do not take the time to come to hearings like this and make their opinions known, because it is not something that is that important to them. So we have heard from a

group of people that advocate and are believers.

So I just want to be clear on that, that there have been groups we haven't heard from, and we have had letters from some of the more skeptical crowd, some who were not able to attend at the time frame that we gave them, who raise important issues that we must not neglect, so that we are truly not just advocates, but that we are looking at this from a balanced perspective, which wasn't even what I was going to say.

DR. GORDON: I think this is a really important thing.

DR. LOW DOG: That wasn't my point.

DR. GORDON: I think we might as well focus on it a little bit now. Is that something you just want to deal with in the context of going through the report, or is there some kind of general statement or tone that not hearing from those people implies, some principle that you would like to articulate?

Joe, go ahead, if you want to.

DR. FINS: If I could just give an example, which is in the second paragraph of the document, that we are citing that 42 percent of the population of the United

States uses a CAM therapy and product. We know where that data came from, and clearly it should be cited, but the other issue is, does that represent accurately the prevalence of this movement, because if someone took a multivitamin, they got counted, or if they had a massage, they got counted.

So in a sense, that is a convenient paper to use to promote an advocacy position. So I think it is the best paper, the best data we currently have, but it is being spun in a way that suggests that it is more prevalent.

The Bob Blendon paper that we circulated about the issue of supplements, the reason I asked that it was distributed was because it suggested that consumers, the rank-and-file Americans in an epidemiologic study, have a desire for more regulation in whatever form it takes of the supplement world.

You would not have known that by listening to the selected group of people who came here, and I appreciate their desire to express their opinion, but what we heard here was not necessarily representative of what most Americans think.

Now, we can debate the science of Blendon's study, and we can debate Eisenberg's methodology, and that is a fair discussion, but I think it needs to be acknowledged, exactly as Tieraona has said, that the advocates came out in a way that people who are opposed or didn't care, didn't. That doesn't take away our obligation to be fiduciaries and stewards for safety and efficacy.

DR. GORDON: Other comments on this general issue? Then, Tieraona, we will come back. I don't want to lose this. We will come back to your comment.

Effie and Wayne.

DR. CHOW: That was my point, that I think it should be stated that we did have some adverse opinions expressed. We did invite them, but we could state that in the overall concept exactly what Tieraona was saying.

What my question really meant to bring out is that we have, and then we have not. That is talking about into the future, what we need to do more of.

DR. JONAS: Yes, I agree. I think this should be stated, actually, up front, this is what we heard from, and this is what we did not hear from. What we heard, the

advocacy that we heard, largely, the advocacy that we heard and the detractors that we heard, we are taking in the context of looking at whether this is something that is going to contribute to the overall health of Americans. So we are contextualizing this, and this is the way we are managing it.

I think this should be up front, that that is how we have received this information.

DR. GORDON: Thank you.

DR. CHOW: Can I make one more? The studies, I respect them and all, but I think David himself admits that it is from a particular population, and I know Francis Brisbane brought out the whole cultural aspect, that people were practicing and weren't identifying that it was CAM that they were practicing, or the different cultures. I think we can all identify with that.

DR. GORDON: Tieraona?

DR. LOW DOG: Yes. I don't really like the citing of this, and one, we do need to reference it, it needs to be clearly referenced in the report, but it has real problems for those of us who acknowledge CAM. I think that there is a tremendous prevalence.

However, I don't think most of us consider going to Weight Watchers going to a CAM practitioner. That is not what we consider to be CAM, and that is what is in this study. I have a lot of people who use a Centrum vitamin every day, but they do not consider themselves to be following CAM.

Further, the problem with the study, which Eisenberg does admit, is that it did not include non-English-speaking people. It didn't hit lots of different people. So I think that it is an interesting thing, but when you then conclude that more visits were made to these CAM practitioners, I feel we have misled a little bit, chiropractors, massage therapists, that we are sort of leading you into believing that these people all went to see practitioners of what we are defining as complementary and alternative medicine. That study clearly includes people that none of us in this room would consider CAM practitioners.

DR. GORDON: Wayne?

DR. JONAS: Maybe what I heard you say is the definition, because all of this really hinges around the definition which overlaps many conventional areas, in

other conventional areas. So maybe we do need to have some type of a definition, which we worked on a little bit before. I am not sure exactly what happened to it, but perhaps that needs to be somewhere in the up-front.

MR. SWYERS: I would avoid that in an Interim Report.

DR. JONAS: We need to describe what we are talking about, I think, a definition or a description.

DR. GORDON: Since we are focusing on this now, I think what would serve everyone best is if we could get a sense in this meeting, as quickly as possible, of what kind of data you would like to use, we would like to use -- not you, we would like to use, and how we would like to deal with the definitional issue, if at all, or descriptive issue right up front. So if we can focus on that, that will help to frame the report.

Wayne?

DR. JONAS: I mean simple way, again to get back to our core principles, is to recognize or acknowledge that there is a lot of ambiguity about the definition of complementary and alternative medicine, and this leads to confusion over what is going to be useful and not useful,

what actually is in these categories, not in these categories. And so the question is, because of that ambiguity, is what -- let's see, what am I trying to say here?

I am saying because of the ambiguity, this makes it difficult. This is one of the challenges in terms of trying to discern what in these areas will truly improve the health care of the American public. In other words, the definition itself is a challenge to our first principle is what I am saying.

DR. GORDON: We can say the definition is a challenge. Where do we go beyond that? Where would you like to go, where would anyone like to go?

DR. JONAS: And then you come up with just your pragmatic description, if you will, of these are the things, these are the areas we have decided to deal with because of what has been presented to us, but this is not the entire field.

DR. GORDON: Okay. And which areas would you include? When you say these are the areas.

DR. JONAS: The ones in the report.

DR. GORDON: Now are you talking about the ones

in this introductory part of the Interim Report? Or somewhere else?

DR. JONAS: I am talking in the report in general. We don't have to summarize the categories that we are going to be dealing with in the introduction. I am not saying that. I am saying that we should make it clear that the whole issue of the definition of what is CAM and what is not CAM is ambiguous, and this in itself makes it difficult to know how to approach and to decide on what is useful and what is not useful for improving the health of the American public, period.

So what we heard was a number of advocates about particular aspects of health care that have this loose affiliation with complementary and alternative medicine. And so we are beginning to deal with some of those categories in the report, end of introduction, and just go into the report. We don't have to define those and describe those actually in the introduction.

DR. GORDON: Okay. Tom?

MR. CHAPPELL: I would like to offer the idea that CAM is a 1992 word that was necessary then, and I think it is already outdated. I think today in the most

positive way of speaking about this movement, along with conventional medicine, it is complementary medicine. And I think the word alternative is a real problem for us at this stage because so much we have heard in the hearings is that we need collaboration, we gain from learning from one another. The different orientation of complementary medicine is value-added, and complementary medicine doesn't presume that it circumscribes the rest of the health issues. I know that is a problem for Joe.

So complementary says what it is for me, and not alternative.

DR. GORDON: I think these are deep waters and we need to keep moving into them.

Effie and Tieraona and Joe.

DR. CHOW: I think we need a statement of how we are presenting the whole package, the definition we are using on CAM, whether we want to state that is nebulous or whether we want to say that we operate on the Office of Alternative Medicine which is in CCA and they say that outside of Western medical science is complementary alternative medicine.

The term complementary medicine is better than

complementary alternative medicine. I would like to see it complementary health care, something to do with health, because when you put medicine in it, it is still pushing things into medicine, and we are really talking about overall health, particularly in view of what we just discussed as our mission statement, et cetera. So complementary health care or something similar, away from medicine.

DR. GORDON: Tieraona.

DR. LOW DOG: I would agree that we need to define the CAM community because we refer to it repeatedly throughout. I agree with Wayne that we need to acknowledge the difficulty with the language itself and this very sort of fragmented group of people that we heard from. I think we need to be real clear about that up front.

I myself don't have an issue with medicine. I think that it is shortsighted to think that medicine is just to treat disease. I think medicine has always been about public health, about prevention, about disease treatment, and for many native people medicine actually is this very, very, very, very, very, very big term that

means much greater than anything we have even been speaking here.

So I am not attached to the word medicine at all. I want to be careful to do away with alternative at this point, only because I am not sure it is necessary to do it, and that sometimes this is used as a true alternative, it is not used as a complement to Western medicine. Some people use massage for their back pain instead of non-steroidals. They are not complementing anything, they are using it as a true alternative.

So I think there is a reason why we have adopted both complementary and alternative, neither of which is perfect, but I think both represent the spectrums of what this is.

The other thing about medicine is truly some of these modalities treat illness. They are not just about prevention. Many of them have value actually in treating disease and treating illness. I don't want us to be shortsighted or limited. Many of these will show in the future, as we learn more, that they are effective at treating different disease states as well as prevention.

So I think we want to be expansive in our

vision, and we don't want to be limiting in our vision as we move forward.

DR. GORDON: Joe.

DR. FINS: I think one way of perhaps handling it is to have -- and Michele offered this, and I am just going to modify it -- to say that definition of what CAM is and what it is not was an element that is under discussion and will be addressed in the Final Report. Not to define it here.

But also I would add that this discussion has regulatory implications about where you draw the line for things like licensure and the like. So I don't think we necessarily have to define it here. I think it is in the executive order, so that is language that we sort of inherited, so we are obliged to go with it, it is the name of our commission, after all. And I think that the kind of rich discussion that we have just had should naturally find its way in a first or second chapter of the Final Report. But it doesn't need to be addressed here. Simply flagging it as an issue that has important conceptual, regulatory and clinical impressions, but not get into it right in this report.

DR. GORDON: Tieraona?

DR. LOW DOG: I am not sure what the time is, but we have till like 3:00 or 3:00. There are 25 pages in this report. We have discussed how we are going to do the process here. I actually think we do need to sort of go through the pages. I don't think we need to go through word for word, we shouldn't be wordsmithing unless we have got a real problem with a particular word. But I do think we need to go through the pages. We need to go through the pages one by one, and we need to know if we have closure on a page. But I think that we should probably get that started when we can.

DR. GORDON: Well, we are on the first page right now. That commitment is there.

Go ahead, Joe.

DR. PIZZORNO: I have a concern about what our commitment is. One of the risks of a consensus process is to give veto to a minority, and so I think we need to have some ground rules as to how we do this, because we are not going to agree with everything. We can't let a single individual or couple stop something also.

DR. GORDON: Is everybody agreed on that? That

we are looking for a consensus process, we are not looking for unanimity, and that there may be --

DR. FINS: Suppose as a preamble we say something like it is the sense of the Commission, and that these issues will be fleshed out. So it takes the onus of a dissent off the table at this point, but it leaves it in play for some future date.

DR. GORDON: Great.

DR. JONAS: And it is the sense of the Commission there was not unanimity on all the issues, and the full richness of the discussion will be fleshed out in the Final Report.

DR. GORDON: Tom?

MR. CHAPPELL: I am having a little trouble with that, based on the advice we received yesterday about showing that you are a very diverse group and that you come with a report that has consensus, and that in having consensus, you have more power and effectiveness in the way you communicate, and that also we not present minority reports.

Those were the recommendations we received yesterday.

SISTER KERR: I agree that that was the recommendation. I disagree with the recommendation. But I do agree in Joe's point that in the Final Report we do have to have space for a dissenting voice. I am not suggesting it, I am just saying leave space.

DR. FINS: I want to just be clear, we are not there yet, but I want to say at this point, I think, to say it is the sense of the Commission, and positions will be elaborated in the Final Report is a way to allow us to reach a kind of consensus and have people sign on to the document as a whole, and not have a deal-breaker on page 14 or whatever.

DR. GORDON: I don't think you and Tom are saying anything very different, actually. It seemed very similar to me.

Go ahead, George.

MR. DeVRIES: I think it is a little premature, at this point, to say majority rules, and if somebody disagrees with something, that they can't somehow express that separately, or there can't be a process that happens over the next couple weeks to reach consensus on that where we truly have unanimity among all of us.

So I think it is premature to say majority rules, at this point. I think what I would like to really say is that I think we need to leave room for the process to work itself through. I think we have a chair who is going to work to bring consensus to the process. We have a staff who is going to work to make sure the language is such that it gets maximum agreement from the group. I think it is premature on that basis.

Does that make sense?

DR. GORDON: That was also the feeling I had from what Joe was recommending, that we are really trying to come to a common sense of where we are in this. I think we also have to leave a little latitude, because this really is the beginning. The whole purpose of the Interim Report is where we agree. I mean, that is really the strength here, is where we agree, understanding that there are areas that we have not fleshed out, there are areas we have not worked out, there are areas of disagreement.

I don't think a couple of weeks is going to be enough to deal with some of those, George.

I think we really need, some of the areas that

we have talked about, that we really need to both have more information and that we need to do some studying between now and October, and that we need to have significant time in October to focus on exactly those areas that are the hard places for us.

So what I would like for us to do, insofar as we can, is to come to areas of agreement now, and understanding, and with the understanding which will make explicit, but -- I don't want to keep repeating it ad nauseam in the Interim Report -- that the Final Report is going to be a much more articulated view of some of the complexities of the issues that we are not addressing here.

DR. FINS: I think it is so important for, Tom always says let's think in 10-year blocks, and for the long-term historical context, fleshing out some of these ideas, the dissent, the controversy, the areas where we can't get agreement, may be the most important thing that we contribute in a historical sense, maybe not for a legislative session, but downstream.

So I think there is a richness to that that we shouldn't excise from our deliberations.

DR. JONAS: I would like to make a suggestion, actually, in terms of the format of the introduction, and actually, the format of the first two and a half pages, which I see is the introduction. That is that we begin with the definitions that we have been given. We have been given some, non-Western medicine, et cetera, and we have gone over those.

We acknowledge in the definition the ambiguity of the whole process and some of the challenges and difficulties that this presents for getting to the goals of the Commission.

We then give the context and background within health care, which I didn't see here, in terms of the trends and the forces that are currently going on in health care that have nothing to do with CAM but are part of this entire movement: aging; chronic disease; costs; side effects; disparities in health care; the health principles and prevention; emphasis on prevention, just put a context around those. We have heard from a number of those throughout. So that is the background section.

Then we need to have a section saying that this is an important thing for the American public, and we can

talk about whatever percentage of use you want to talk about. I mean, I would use Eisenberg. I mean, it is there. There are problems with it, et cetera, but I would at least say this is an important area for the American public, and that complementary medicine may be important also because it may provide opportunities to address some of these larger health care issues that we have just outlined in the background.

Then we go to our operating assumptions that we just described here. These are the assumptions, whether we call them beliefs, principles, or whatever, these are the assumptions off of which we operate, and then go into the general description of what the Commission has been doing, and that type of thing. That, in a format, provides us a solid introduction, grounds it in the health care delivery system and says this is an important part of that.

DR. GORDON: I would like to talk about Wayne's outline of the introductory section, but if there are other comments before that.

Tieraona, did you want to say something?

DR. LOW DOG: Yes. I would sort of echo that.

I think there needs to be more of a contextual framework of leading into why this movement is here, why it is happening, put it in some sort of historical and social context, what is the driving force behind it.

I would rework a little bit of this article because there is going to be an article coming out in one of the journals that is basically all about how misleading these Eisenberg studies have been. I don't want us being set up for that. I think you could use it as a stepping-off place to say, even here, in these studies we find conflict, or we find ambiguity, over the terms. I mean, I think you could use it as support.

I would fluff this with some statistics, though, too, when you are talking about, particularly, those with cancer, using a lead-in sentence, "Surveys have shown that up to 60, 70 percent of women with breast cancer are using." I would fluff those up a little bit, and then use it as lead-in so it gives a little bit more of a richness to text.

So I would agree, more contextual, historical, social framework, and then buff it up a little bit with your data and references.

DR. GORDON: Joe?

DR. FINS: May I can make a suggestion that I think what Wayne suggested is absolutely correct. I have been arguing for this historical, sociologic context. I don't think we have had testimony that allows us to write that yet, but I think we should say here that we will address that in the Final Report.

DR. GORDON: No --

DR. FINS: Well, what is the basis of the --

DR. GORDON: I think the basis is that some of us have been spending 30 years in this movement and have studied the movement extensively, and we do have a sense of the history and where it comes from. We talked with various people and read all the literature, read all the sociology, read all the history.

DR. FINS: The difference is between autobiography and biography.

DR. GORDON: Understood. I think that we are not dealing with either one here. What we are dealing with is an assessment of the terrain that is out there, and I think you have to take a look at it, Joe. I don't think this is going to be autobiographical. This is much

more a question of, where does this come from historically, where does it come from sociologically, where does it come from in terms of the needs of people with chronic illness, for example, which is the issue that Wayne raised.

It is pretty clear we are not so much talking about the sociology of the movement, we are talking about the demography, if you will, of the people who have been seeking out these treatments.

DR. FINS: If it is simply the demographics, I have no objection, but if it is an interpretation of the larger meaning and why we are here as a commission, that, I think, is interpretative, and I think any of us who are already around this table are really precluded, in a way, from offering an interpretation, because as historians, you can't write a history of your own time. So we need to have a little academic detachment.

SISTER KERR: Joe, I just remind you of what you have offered both days to me, a reminder of a process that we will get something down of context, but it may not be there until the Final Report. Though I would second what Wayne said, and also for myself, I would like for us to

have a moment and invite our writers to see, also, what is inspirational about this moment in history, and see some language in there.

Again, we will work on that as we go along. This is a call from the people, and I want to be sure that is in there in some way.

DR. GORDON: Joe, that is really what I am talking about, is that the reason there is a Commission is because so many people out there are using these therapies. They want to know more about them. They want to have more access to them. That is pretty clearly the reason why we exist.

Are you comfortable with that?

DR. FINS: There are levels of complexity about why we exist. That is one of them.

DR. GORDON: Right.

DR. JONAS: Yes. I mean, it would be nice to have a full background of the health trends and how those relate to these areas. I mean, there are multiple other reasons, I think, also, including globalization and the information age. Rising health care costs are making people say, gee, you know, how can we afford it? So there

are multiple things.

DR. GORDON: Wayne, what I am thinking is that all of those, very briefly stated, are a part of the background. I mean, obviously anything that anyone says is some kind of interpretation of the facts, but there seems to be enough agreement across observers.

DR. FINS: Let me just make my last appeal, and I will never bring this up again. Let's try to get a historian or some scholar outside the movement who has taken this on, and try to get him or her to give us an academic presentation, maybe to start us off in October as a plenary, to help us contextualize this and jump-start the writing of the Final Report.

MS. LARSON: Let's get Bill Moyers to give us a few tips.

DR. FINS: Or somebody, you know.

DR. GORDON: Yes. I agree it is a good idea. We actually did that with the health professions. We had the guy from New Jersey who came and did give us a sense of the history of the development. So we want to pay attention to it. We will pay attention to it.

A decision that we have made -- and Joe and I

were having this conversation earlier -- a decision, at least a kind of consensus that developed in the comments that Commissioners made, is that people would really rather not have more presentations, but would rather have, if we are going to get material, written material that we can look at ahead of time.

So I want to come back to this, after this discussion is over, because one of the other items on our agenda is, we have already mentioned some of the areas that we want to look at again in October. This is clearly another of those areas.

I want to make sure that we agree that we are not going to have more testimony. If we want to have more testimony, we have to understand the time-consuming nature of that. We can do that.

DR. FINS: How about if we commissioned a paper?

DR. GORDON: That's fine. That is certainly something we can do. What I am saying is, I agree that we need to have that information. The question that we can talk about, we don't have to take up time in the session but that we can talk about, is whether or not we want to have more people come and testify, or whether we simply

want to work with written materials.

Jim, do you want to say something?

MR. SWYERS: Yes. Just to address Wayne and Tieraona, and Joe's comments, we have already started writing the first section of the report.

DR. GORDON: The Final Report.

MR. SWYERS: The Final Report, and Wayne's outline pretty much mirrors what we are doing. There will be a lot more richness and information in those sections. We started doing that, but for us to try to abstract the report before it is finished is hard to do.

DR. JONAS: To me, there needs to be some kind of contextualization in the report also, whether it is a simple trend and discussion of the demographics and the issues. The factors that have led us to this point, I think, need to be in here.

MR. SWYERS: We have done some of that. We can pull some of that information out and put it in this.

DR. JONAS: It doesn't have to be the whole thing, but it would be nice to have some.

MR. SWYERS: It is just going to be sort of a surface discussion.