DR. GORDON: Okay. So we can take a look at that and maybe either pull some out, but there is agreement that we need some background. Is that correct?

If I seem repetitive at times, it is because I want to really make sure that we do have a general agreement about what needs to be in the report, and the more we can get clear about what needs to be in there in this meeting, the easier the rest of the process is going to be for everybody.

MS. LARSON: I would like to move very quickly, that we are decided on that, and that we can get through to Tom's area, wellness, because we have half an hour before we are going to break.

But what Wayne outlined and what Jim has said, yes, we are already doing this. Then the specifications of the contextualization, I think, are really important, but I think that we can continue to beat a dead horse right now.

DR. GORDON: Is there anything you want to say about that before we stop beating that horse?

MS. LARSON: I have, maybe, two sentences, but I think I will table them for another time.

SISTER KERR: Can I take your two sentences? Thanks.

I just want to say that for me it is tremendously important that the Interim Report have this context. I know we just said it. To me, it is symbolic that if we do not do it and just move into these recommendations, it is not emphasizing what we understand is the spirit and the call from the people to do this, and it sets the stage for the listening. I truly believe that. Thank you.

DR. GORDON: Okay. Tieraona?

DR. LOW DOG: Yes. I echo that.

Could we just focus so that we are not in danger of scope creep throughout this day? Could you please define again for us, real clearly, what is the actual, in just a couple sentences, intent of this report, and who is the audience, and who are we aiming it for, so that we are very clear on that throughout the deliberations.

DR. GORDON: Sure. The intent of the report, and Steve will correct me if I stray, is to provide an update to the Secretary, and through the Secretary of Health and Human Services, to the President and to the

Congress, about our activities so far. That is sentence one.

It is also to provide an update on our activities, to make some specific recommendations about which there is general consensus, which may be used to help shape legislative and/or administrative initiatives, and to give some sense of where we are headed with the Final Report, but that is really subsumed. I see that as emerging out of what we have been doing so far.

So that is the basic intent.

Would you agree, Steve?

DR. GROFT: Yes, I think that really summarizes it. One additional fact or direction is that we have to give the public some information about where we are going, and give them the opportunity to comment on what our feelings, our beliefs are, and the direction of the report. That is part of it.

DR. GORDON: The primary audience is Secretary of Health and Human Services, the President and the Congress, and through them -- and this is what Steve is emphasizing -- to the public, to give us feedback about the report, to tell us where we are on target as far as

they are concerned, where we are not, what else we need to be looking at, what concerns we have or have not addressed, and how they feel about how we are proceeding.

DR. GROFT: I think, as Tom mentioned, CAM started back in 1991-92, with the introduction of that terminology. The same with this Commission, where the introduction of the concept of the Commission was probably 1998. So we are three years down the road, and to say, are we, as we see it, going on the right track, or does the public feel that we should be going on another track, or picking up additional information that we haven't considered at this point in time, I think that is important also.

DR. GORDON: Okay. Any other questions about that? About the intent and the audience?

[No response.]

DR. GORDON: Okay.

SISTER KERR: Is there any addendum to that, where you said that this report is to speak where we have consensus? If I were the public listening, I may go, well, for gosh sakes, why aren't they talking about that and that? Is there any way to clarify that for the public

reading?

DR. GORDON: Clarify what? I'm sorry.

SISTER KERR: These are only the points of consensus.

DR. GORDON: Yes. We can certainly make that clear. I think that is a very good point. We will make it clear.

Does that make sense? I think that what we need to do is to make clear exactly what we are doing and not doing in this report.

DR. LOW DOG: That is not what we said just a little while ago, though, because now we are saying that this report is clearly where we have consensus, and earlier we were saying that we may have ambiguity, we may not have unanimity.

DR. GORDON: We have consensus that we have ambiguity. No, I am not just playing with words, what I am saying is that we will say where we are. If we have ambiguity about certain areas, or if certain areas are unresolved, I think it is important to say that, that we understand that.

The point is that the consensus is about all of

these issues. Consensus doesn't necessarily mean that we are in agreement about the particulars. It means that we are in agreement about where we are with the particulars.

Joe?

DR. FINS: I think the best way to address this is with text. I mean, I think it depends on where we are, and I think we should go to the Tom thing so we can take advantage of his leadership on this.

DR. GORDON: Okay. The Tom thing.

[Laughter.]

DR. GORDON: Do you think that is an appropriate title in the report? We will call it "The Tom Thing." Is that okay with everybody? Can we move on to the Tom thing?

No, seriously, can we move on to the section on wellness at this point. So we will move right ahead?

As we are turning to that page, Joe Kaczmarczyk left me a note, that Professor Orzak, who presented the testimony on the evolution of professions, is developing a more expanded version of his testimony, which will be available to us. Joe mentioned that we can ask him, if we want, to supply other sociological and historical

information.

So that may be one way for us to go.

MR. CHAPPELL: Are you ready for my thing?

DR. GORDON: Yes.

MR. CHAPPELL: Could you turn to page 19, and turn off any other mikes, please?

Discussion Session VI: Wellness, Self-Care and Prevention

MR. CHAPPELL: On page 19, lines 7 through 29, there is a good contextualization of the evolution of wellness, self-care and prevention as a way of taking care of yourself.

I want to direct the Commission's attention to the next page, page 20, lines 9 through 17, and in directing you to these lines, I don't have anything to process that was otherwise in our booklets here of a menu of suggestions because they will just have to stand as a menu of suggestions that fall within the guidelines of these five categories in 9 through 17.

The first category is addressing education. The second category is really talking about education, again, and then the third within the health care professions, more education, and then four is the workplace, and five

is sort of national initiatives for the entire population.

So this circumscribes the suggestions that have been coming forward in the hearing process, and I think the report appropriately targets these areas of attention and need and development.

So, first of all, teaching, promoting and encouraging CAM approaches to wellness, self-care and prevention at all levels of the educational system.

Is there consensus that we should be striving to bring education of CAM services, products, at all levels of education?

DR. GORDON: I just want to make a point of process. What Tom is doing is not addressing up front the text, and you are not addressing it because you are satisfied with it --

MR. CHAPPELL: Yes.

DR. GORDON: -- or you have no particular concerns about it. So do you want to address the text if anybody else has any concerns afterwards, and go to the recommendations first? Or would you rather address the text first?

MR. CHAPPELL: I will come back to it, if you

would like me to.

DR. GORDON: Is that all right, or do you want him to address it first?

MR. CHAPPELL: I would like to be focused.

DR. GORDON: Okay.

MR. CHAPPELL: At this point I would like to be focused on these five areas.

DR. GORDON: Okay. Is that fine with everybody? I would like to let people who have taken the lead in these areas take the lead in the discussion, and then if we want to go back and go over it a different way, we will do that later. Okay? Is that all right?

SISTER KERR: Where does it fit in if you have comments on language? Now or later?

DR. GORDON: What Tom is asking is that we look at the recommendations now and that we come back to the previous text, though we can obviously deal with the language of the recommendations, but that we deal with the text that leads up to the recommendations after we have dealt with the recommendations.

DR. FINS: I think that the way it is textualized, the recommendations, is problematic, and so I

think it is sort of hard to dissect that out. Let me just give you an example of what I am thinking about. On page 19, you know, in lines 17 to 20 or so, there occurs what will call CAM creep, where CAM becomes prevention and not a subset of prevention.

I think we really need to avoid CAM creep because I think it decreases the credibility of CRAM -- CAM.

DR. GORDON: You mean canned CLAM.

[Laughter.]

DR. GORDON: I hear you, Joe.

DR. FINS: Let me just finish. I think explicit mention here of , for example, and the excellent efforts of the United States Public Health Service in promoting prevention and health education and those kinds of things, that this is in conjunction, that CAM does not replace prevention, but is an integral part of these wellness strategies.

Then we go to the following page, where you have your five recommendations, and the way it is written now, it sounds sort of like we are proselytizing for CAM, when in fact we are now advocating an approach to prevention

which includes CAM.

I don't know if I am clear, because I am tired, but that is --

MR. CHAPPELL: That is okay. I am trying to help us avoid a CAM of worms here and get us right to the recommendations to see whether or not we have any consensus.

SISTER KERR: Where are the recommendations? I am on page 20.

DR. GORDON: Page 20. Charlotte, are you looking at the one with the numbers on the side of the page?

SISTER KERR: Yes.

DR. GORDON: It's line 9 through 17 there. There are five recommendations.

MR. CHAPPELL: I would just ask if I could be the facilitator of this section, please. I have been asked to do something, and I would like to be given a chance to do it.

So for everyone's benefit, what I would like to do is to take you first to the recommendations in lines 9 through 17, after whether or not we actually have

agreement, so that the reporters can know our wishes. And then we will go back to see if we need to clean up any of the other language, the precepts to that.

Yes?

DR. LOW DOG: May I respond to that? I have problems with the recommendations, because they are too vague for me. And it goes back to our ambiguity of what CAM is.

MR. CHAPPELL: I was going to take them one by one.

DR. LOW DOG: Well, with all of them, but where we say CAM approaches to wellness, self-care and prevention at all levels, integrating CAM approaches into programs of health education for children in elementary schools, what exactly does that mean that you are teaching my second-grader? I mean I am interested in prevention and I am interested in self-care, but that is way too vague for me because CAM is huge. I have no idea what that means.

MR. CHAPPELL: So you are really asking whether we have a curriculum in mind, how would the curriculum be developed. So this is not specific enough.

George?

DR. BERNIER: Again, I want to stay focused where you have us, Tom, on the recommendations. But I agree in the sense of the vagueness, but I wonder if it is vague because in the previous text we don't say, you know, in this context wellness means good nutrition, exercise, not smoking, doing the things of self-care to take care of yourself, and that this has been shown to reduce chronic illness and other disease.

By specifically saying this is what it is, then you put into a context later when you are basically making recommendations.

MR. CHAPPELL: Okay. Thank you, George. Tieraona?

DR. LOW DOG: My response to that is that throughout my medical training, exercise, lifestyle management, smoking cessation, a month at the wellness center, all of those things, and almost all of the research that has been done and paid for by that has actually been in conventional medicine. The Public Health Department, OSHA, job training safety, all of this is in and under the Public Health Department and in preventive

medicine.

So I am not clear when we say CAM approaches. You are going to have to define what is different or unique or distinct. If you are saying exercise, lifestyle, nutrition, be clear what you are saying. But to say CAM approaches, you have lost me there because that is what public health officials have been fighting for forever. And the work that has been done in that is in conventional medicine.

DR. GORDON: Are there other comments about this recommendation? Effie?

DR. CHOW: I think there is so much question on this and ambiguity because again we don't have the definition of CAM. I go back to my work. And back here on 19 it begins to describe what CAM approach is, line 24 to 9 of the next page. But whether that is specific enough for the discussion to then take a look at what CAM approach means in the recommendations.

So in a way taking the recommendations without kind of going through their principles, again --

MR. CHAPPELL: Yes. I am happy to take your direction on this and turn now to 19 and start at the

beginning and just see whether or not we are absorbing all of the precepts that go into the recommendations. So why don't we take those paragraph by paragraph.

So I am at line 8 now on page 19. I just ask you to bring your comment at this point on the three paragraphs there, through line 19, if you could. Joe?

DR. FINS: Yes, I would just again go back to the notion of trying to contextualize this. You used the phrase before in our small group like CAM is value-added. And so I would say here that CAM is that sentiment, and we don't need to wordsmith it, but it is value-added to all the primary and secondary prevention efforts and wellness efforts that Tieraona and I have spoken about, that are part of the mainstream medicine, which would have to get us on lines 19 and 20, taking up this language.

I think it is patently untrue that prevention activities frequently take place outside the conventional health care system. It may take place outside the health care system, but it also takes place within, and some of the things that you are saying are truly preventive may not be efficacious.

I mean, you know, we know pap smears are good

prevention, but we are not sure about some of the other modalities which are cited in lines 26, 27, 28, as proven to be preventive.

So I think we have to acknowledge the preventive services that are in place, that are efficacious, and then say that the people we heard from, consumers, also want these other modalities for additional enhancement of wellness and strategies for well-being and prevention.

MR. CHAPPELL: Jim?

DR. GORDON: You are making a distinction between those activities in prevention for which there is good evidence and others for which there may not be good evidence, but people are using?

DR. FINS: There are two points. One is that most prevention is happening within the mainstream, mammography, pap smears, smoking cessation, cholesterol lowering, exercise, et cetera, in the context of things that you might see in the United States in the Healthy People 2010 sort of thematic.

The second point is that those modalities have proven intervention characteristics, and we talked about yesterday some are better, some are worse. Quiacs are

less good than pap smears, for example, in preventing colon cancer versus cervical cancer. We have that information.

Some of the things that are down here that are not as proven yet, it doesn't mean that they won't work, but they are just not proven. So there are two points that I am trying to make.

The more important one is to contextualize this section against all the other efforts that have been led by the United States Public Health Department.

DR. GORDON: Yes. No, that point I understand, and I think we are clear on that one. That is a very good point.

The second one, I think, is an important point, too, and the question is how to work with that point. And I think you are pointing to some kind of ambiguity in the language that we may be focusing on some things which are much more in the mainstream, and then we are focusing on others that are CAM, and we are kind of lumping them, or at least they seem in the text to be lumped together a bit.

Yes?

MS. LARSON: My only point was to mention that what you were saying is it is disease prevention. That is a different thing versus wellness promotion, and this is what we must make a distinction in. That is what we are trying to get to here.

DR. GORDON: Does everybody understand that? So your pap smear would be disease prevention.

DR. WARREN: Pap smear is not prevention.

MS. LARSON: It is detection.

MR. CHAPPELL: Just a moment, everybody. We will just go in some order here, and we will give some people a chance to speak that haven't had one. Don and Julia, and then Tieraona.

DR. WARREN: Well, what I don't understand here, you are calling a pap smear prevention. Pap smear is detection, it is a screening. It doesn't prevent anything. It picks up disease, dysfunction, just like a dental X-ray picks up dental decay. It doesn't prevent it.

MR. CHAPPELL: I agree.

DR. GORDON: I'm sorry, we are going to listen to these other people now.

DR. WARREN: So I like what he has got here. I like what is on this page. It describes it. It is disease screening. That is exactly what he has listed it as, and that is what it is. It is not prevention. Mammogram is a screening, it is not a prevention. In fact, it may be a causative factor in some studies. So I think what we have got here is the right thing.

DR. GORDON: Julia?

MS. SCOTT: I was going to say pretty much the same thing, except I see it as secondary. The things that you are talking about are secondary prevention, but I think the emphasis or the distinction here is a system that is geared more to the detecting of diseases, whereas, I think many of us believe CAM is an addition in wellness.

DR. LOW DOG: I think all of these are important. I think that what I want to caution us against is using divisive types of language and not acknowledging the tremendous efforts that have been done in conventional medicine towards public health, wearing seat belts, bicycle helmets. My god, the big initiatives that have been done on that. That is not disease-oriented, that is to prevent you from dying in a car accident. It is

prevention, pure and simple.

Now, where we are talking about this with meditation and biofeedback and stress management, things that promote wellness and health, that is very different in some ways, but there is overlap. I think all we have done is, one, I think we need to rework some of those sentences there to honor all the work that has been done, but then to say, we find that there is potentially some very exciting techniques or whatever -- somebody smarter than me with words -- there is some very exciting stuff in CAM, and then mention them: meditation; biofeedback; imagery; tai chi, that may serve to promote wellness and improve health.

I think we just need to be careful with our language, and I think there are some exciting areas here that can improve health.

MR. CHAPPELL: If I am getting the sense of the comments, it is that we want to be as inclusive as possible here about what has gone on before and what has been added to, what has been contributed to.

DR. LOW DOG: And be inspirational. It is exciting work. What is out there that can help us.

MR. CHAPPELL: So far, I am hearing that we need to be clearer about the credit that needs to be given to the movements that have preceded and what CAM has contributed. I am just hearing that.

Joe, and then Effie, and Charlotte.

DR. PIZZORNO: One of the huge dangers is defining CAM as anything that is not conventional. We must remember there is overlap in these fields.

Second is I am concerned that we not lose our understanding of why the public is going to CAM professionals. While it is true that there is some prevention taught in conventional medical schools, and I understand that now most medical schools actually even offer courses in nutrition, that is only a recent development. The reality is that what is described on this piece of paper: nutrition; lifestyle; health promotion, people go to CAM professionals to get it because they do not get it from the conventional medical practitioner.

There are some enlightened people like Tieraona and others, actually many sitting around this table today, who are medical doctors who understand that, but the vast

majority of services being provided to the public don't get that, and that is why people go elsewhere.

In terms of the numbers, I agree that there are some significant problems with Dave Eisenberg's work. However, let's just do some simple math. There are 600,000 medical doctors in this country. My understanding is, only half of them actually see patients. There are about 100,000 alternative medicine practitioners, when you look at chiropractors, neuropathic doctors, acupuncturists. If you add massage therapists to that, that comes out to 200,000. So the reality is there is a tremendous amount of care being provided right now.

If you look at areas like Washington State, where we have equality of insurance, equality of life insurance, one community hospital did a survey -- this was in Kirkland -- and 75 percent of the people in Kirkland went to a CAM professional within three months before the survey was done.

So realize, this really is happening out there, people are getting services they don't get from conventional medicine.

DR. GORDON: Let me just interpolate. Can you

give us that survey? Because that is a very interesting one.

DR. PIZZORNO: I will see if I can get others. That was three years ago, and probably the numbers are higher now.

MR. CHAPPELL: Effie is next. Thank you, Joe.

Effie.

DR. CHOW: Some of the basic principles, adding to what Joe says, is that prevention in a medical system is still doing things for the fear of disease, and prevention in CAM is really doing things to promote health, for the love of being healthy. It is a positive aspect.

I would add to his list, Joe's list, of why people go to CAM practitioners, because they are listened to and they are touched, physically touched and mentally touched.

So I think I like the gist of what this is saying. It does need to be elaborated on. Do give credit to the Western system about the prevention, but you see, it is still all sort of fear of accident and those things. You know what I am talking about?

So anyway, I like the gist of this, but it needs to be elaborated.

DR. GORDON: Tom, let me just interpolate. If you are making a suggestion for what needs to be elaborated on, aside from the references to prevention and Healthy People [2010], which we got, we have got that one down, what other elaborations?

If you have something specific, please say it now. The more specific people can be, the more helpful, the more we can get a consensus. Then we can get it down here, okay.

MR. CHAPPELL: Go ahead, Charlotte.

SISTER KERR: I want to keep, for myself, using the discipline today of going back to what we identified as our guiding principles. One of the principles is that people have a right to choose the modality and the practitioner of choice.

Having said that, and pointing to Jim's request of what other elaboration, I am wondering if we need to include the possibility of what may be there as healing opportunities, that which is not spoken yet as health promotion; the inclusion of practices that may not be

spoken, but are things like the coins on the back or the bee stings for the MS.

How do we create the space to safeguard the right to choose what the person wishes? Do you understand?

DR. GORDON: Charlotte, what I would like to do as the guardian of the overall structure is to say, I would like to put that into access because that is really about treatment. This is really about wellness and health promotion.

MR. CHAPPELL: This is also trying to describe a background to specific recommendations. So it is pointing us to five recommendations.

Wayne, I think you were next.

DR. JONAS: Yes. I think I agree in general, but I think we should go back to the principles that we outlined, and I wish we could get them up on the wall so we could refer to them.

I think Number 3, that we identified, really is that we believe enhancing the healing capacities, and that this provides an important, my wording, perspective and opportunities for prevention, treatment, palliation of

disease, and the enhancement of wellness.

I think that that is the core issue that we are talking about in here. I agree that we need to contextualize this within the tremendous efforts that are going on in conventional medical care for prevention. We need to use that word "prevention." That is what it is. We need to explain that. I think by describing those efforts in Healthy People 2010 is a great way to ground that.

Then we can add onto that and say that there are a number of practices outside the conventional health care system, apologize for David Eisenberg's address, focus on health promotion that may be useful in the prevention and the treatment of disease, and the enhancement of wellness and self-care, and in this way acknowledge this, and then acknowledge that there are additional items that are not necessarily addressed in those activities that we still feel are very important, not just for prevention, but enhancement of wellness, also for the treatment.

I mean, health promotion, and the health promotion practices are also useful as treatment, and Dean's program is an example of this.

MR. CHAPPELL: Okay. Thank you, Wayne.

I think Wayne has summed up the sentiments that I have been hearing, that we have been trying to refine in reacting and responding to the text as it was presented. I just want to find out whether any of our writers have captured Wayne's statement. I don't mean Number 3, but --

DR. GORDON: No, no, no. I have those, and I am sure Jim Swyers does as well. I have them down.

Tom, I just wanted to remind you of the time, and that we need to come back to the recommendations as well, if you are ready to do that.

MR. CHAPPELL: I think we are ready to do that.

Corinne?

MS. AXELROD: Just to say, as a primary author of this section, I will certainly work with Wayne and everybody else to make sure that we have captured everything people have said.

MR. CHAPPELL: Good. Thank you.

I appreciate you bringing your concerns forward, everyone. Now we will turn to page 20, line 9. On the first recommendation, it has been pointed out that it is too simplified to refer to CAM approaches if we are going

to recommend a curriculum to an entire educational system, that we need to be more specific. In fact, we need to develop a curriculum.

DR. GROFT: If I may caution you, Tom?

MR. CHAPPELL: What is that?

DR. GROFT: Tom, I don't think it is really our position to develop a curriculum. I think we have to think beyond that, that someone else is going to have the responsibility for implementing these recommendations. I think for us to try to develop everything that we are suggesting is impossible.

MR. CHAPPELL: Okay.

DR. GROFT: I think it is more important to identify what needs to be done, and then have it implemented.

MR. CHAPPELL: Tieraona is recommending that we be more specific when we use the term CAM approaches.

DR. LOW DOG: My problem was integrating CAM approaches into health education for children in elementary school. I mean, to me, I could not support that sentence because that is just too ambiguous for me, of what you are going to teach my child in school.

DR. GORDON: I think there is potentially a middle ground of giving some examples. We can't articulate the whole curriculum. Clearly, we can't be so vague, if we talk about nutrition, exercise, stress management, however you want to say it, as examples.

Yes?

MR. CHAPPELL: Charlotte?

SISTER KERR: I just want to say again, I would like the group to either say yea or nay on what I will continue to point out, unless you can convince me otherwise. When we say CAM approaches, I do believe this morning was very important, that what we want if we are going to do school programs or whatever, we want the principles and the practices to be taught, and that goes all the way through everything, integrating CAM principles and approaches.

Do you agree with that or not? I mean, we are going to grow in explaining what those principles are.

DR. GORDON: I do, but I think it is a question of asking that you are asking everyone the question.

SISTER KERR: My fear is that we are talking about integrating approaches means integrating modalities.

It is like how every course looks that says we now integrate CAM in our continuing education program. And what is it?

There is a lecture on biofeedback, there is a lecture on acupuncture. Nobody does a conceptual framework, which we haven't even gotten into in terms of energetic concepts, at least the principles.

MR. CHAPPELL: Any other comments? Effie?

DR. CHOW: That is my platform, too, constantly, is that we have to have the overall as well as the technique. Perhaps we could say "appropriate CAM approaches," and then give examples. Then, of course, "appropriate" is up to your school, what is appropriate to it.

MR. CHAPPELL: That does seem to be the sentiment of the circle.

Yes, Dean?

DR. ORNISH: Just again, in the same spirit of avoiding using targets, because if you are not specific, you are going to have people saying, oh, so you are going to stick needles in my kids? You know. I mean you are going to have my kids taking herbal supplements that I

haven't approved? I mean let's not give them any easy targets.

MR. CHAPPELL: Thank you. I think the second recommendation is the same as the first. Could I ask for clarification of the writers on this?

DR. TIAN: Yes. What would you say, Corinne? I would say it is a subset of the first, yes.

MR. CHAPPELL: And so we move to the third item, assuring that all conventional health professionals have some training and education in CAM approaches to wellness, et cetera.

SISTER KERR: I still don't feel like I have either gotten affirmed or negated on CAM principles and practices to wellness and self-care. Are we going to leave out the word principles? Or beliefs? Whichever one we decide on.

MR. CHAPPELL: It is my understanding that we are going to be incorporating that throughout the entire document, where appropriate.

DR. GORDON: Let me say my intention of using the word approach is that an approach is not just a technique, it is a mindset as well. And that is why I use

the word approach, and I am pretty sure that is my word that is there, because it includes both. So it is also a word that is somewhat more neutral and is not likely to raise a red flag. I just give you that.

MR. CHAPPELL: Wayne, please.

DR. JONAS: I just had one suggestion that might help with this, and that is that we alter that to say, for example, in No. 3, assuring all conventional health care professionals, and we could do this in the others, have some training and education in the role of complementary and alternative medicine in wellness, self-care and prevention. And that would be a little broader, and it could be done throughout.

DR. GORDON: Tom, does that work for you?

DR. JONAS: The role of complementary and alternative medicine.

MR. CHAPPELL: Well, we will take that under advisement.

Go ahead, Joe.

DR. FINS: I think that fits with the notion of how we modified cross-training yesterday, that people were aware of the other modalities, but they weren't being

trained to do the other modality, and a conventional practitioner needs to know about the role, but may not necessarily endorse.

I would also say that on line 9, I want to just point out, because of what Dean said and what Tieraona said earlier, that we are not necessarily recommending this, we are saying there is strong interest in this, which I think also is kind of -- it puts a little distance from the Commission from the recommendation. But we are just saying we are reporting back what we heard.

MR. CHAPPELL: So, in the interest of time, then, let's concentrate on edits, and we have one edit to the Item 3, the third recommendation.

DR. GORDON: Tom, before we do that, I want to make sure that everybody understands the point that Joe made, and that we are in agreement about that point. It is that we are at a slight remove from making these, and that was conscious, right, Corinne? This is a conscious choice that we are at a remove from making these as recommendations.

In some instances we are making recommendations. Here we are saying there is significant public interest in

this area, and leaving the room open to make recommendations more specifically in the Final Report. This gives everyone a chance to respond to these. I think that is the thinking that we have.

MR. CHAPPELL: Thanks, Jim. Yes, Effie?

DR. CHOW: That is portrayed right from the beginning of the article here. So witnesses testified, and et cetera, et cetera.

MR. CHAPPELL: All right.

SISTER KERR: My last comment is just to say I believe this is a teaching document, and for myself in a few seconds of reflection, even though I appreciated Jim's interpretation of approaches, I think because the mind has not moved, that approaches still means modalities. I would personally like to invite the group to consider again whether or not we want to say things like principles and practices or some other word that implies we are in a consciousness change. No consciousness change, no new creation of health in my mind.

MR. CHAPPELL: Okay. Gerald? Thank you, Charlotte.

DR. GORDON: You are asking for some kind of

agreement or disagreement around the circle, right?

DR. FINS: I think maybe at the outset, in the early part of the report, we might say by approach we mean something greater than modality, and somehow have a definitional footnote or something, so that we can say when we are talking about a modality, we are talking about approach, we are talking about a more comprehensive system of care or something.

Yes?

MR. CHAPPELL: I would like to comment on this point. Approach is sort of an implementation. Belief is a very clear grounding. And wherever possible, we should be pulling the beliefs into the text, the word belief into the text, to give authenticity and strength to the recommendation, and to give integrity to the whole document.

So I agree with Charlotte that approach needs to be re-looked at, revisited, to see if we can strengthen the recommendation in terms of its relationship to what it is we said we believe in.

I would like to just see whether or not that is a sentiment of the Commissioners. Do we need to spend a

little more attention on that?

Yes, Julia.

MS. SCOTT: I think I agree with that, but I also want us to be careful when we are talking as Commissioners, and when we are talking as what we heard or what people told us. I don't know that we heard that people told us what Charlotte is inferring and you are inferring. This sentence starts with "Information provided to the Commission indicates there is a strong interest."

So I mean, I hear what you are saying about the word "approaches" kind of losing the meaning, but I think I am more in favor of what Joe has suggested, that in the beginning of the report, we are very clear about how we are going to sharpen our definition for beliefs or principles.

SISTER KERR: I have a response to that, if I may.

MR. CHAPPELL: Yes, Charlotte.

SISTER KERR: If you remember, it wasn't everybody, but in New York. I forget the names of the people, but they were founders or foundresses of schools.

They were two women doctors, I believe, who had a long history in complementary medicine. They spoke, and I remember it because of my own bias, without the work at the level of the philosophical level, epistemological level, that nothing changed, and if you didn't get to the essence of the change at the level of consciousness and conceptual thinking, it wasn't the real thing.

So I heard it, and I thought it was a great point, Julia.

DR. ORNISH: Well, again, playing my role here, I can just say that the word all in Points 3, 4, and 5, in lines 13 through 17, that all conventional health professionals have some training, that we integrate CAM approaches to wellness, et cetera, into all workplace health activities, we explore placing CAM approaches into national health and wellness initiatives for the entire population.

I really think it would be wise to try to tone that down a little bit, because even if you say there is a strong interest in these things, that semantic distinction is going to get lost. I can just tell you, people are going to say -- I mean, you just have to appreciate what

kind of reaction that is going to get in the workplace, for one thing.

I mean, employers are going to look at this, and they are rolling back the repetitive stress industry. The Commission spent four years and thousands of witnesses talking about the importance of repetitive stress injuries. They have completely rescinded it because even something as well documented -- we are not talking about epistemology here, we are talking about something that is pretty obvious to everybody -- that was well documented, and when employers saw that, they were able to lobby to get it removed. Just that line alone will get a lot of people against this report.

DR. GORDON: So, Dean, I think your point is well taken. In places where we are too inclusive, or we seem like we are mandating something, we have to tread lightly.

DR. ORNISH: We are mandating this, when you are talking about everyone, the entire population.

DR. GORDON: I understand. I understand. We are not actually mandating it. We are saying that people suggested, but I think you are right, the distinction will

get lost.

DR. ORNISH: By the time you get seven lines down, there is a very small distinction in most people's mind between strong interest.

MR. CHAPPELL: Fine. I think Corinne points out it is already out. Thank you, Dean.

Tieraona?

DR. LOW DOG: I appreciate so much the use of the word "belief and principles." I just want to be careful where and when we use it, because if you read the sentence, "integrating CAM approaches into programs of health education for children in elementary school," it sounds very different than when you say, integrating CAM beliefs into programs for children in school.

Now, you may be talking about the same thing, but people hear the word "belief" in different ways. So I think, in some places, we want to talk about our beliefs and our values, and in other places I think that word might not be the best word. I would keep the "approach" here, and I would define "approach" earlier, but I wouldn't shy away from using it in places where I think it sounds appropriate.

But here, I know I can tell you, as myself, I have some issues with beliefs and when you start talking about what things, what kind of beliefs you are going to teach my child in school.

SISTER KERR: I couldn't agree with you more, which is why I don't like the word "belief," and principle includes belief, but it is coded as guidelines. I couldn't agree more, but I am not arguing on the content you were. I was arguing for when we make a statement of what we want to do, that we be sure we put it in a theoretical framework.

MR. CHAPPELL: Yes. Let me point out that the operating word universally for beliefs is "values." You can use them interchangeably. When you want a more neutral response from an audience, "values" is the word.

I am also hearing Tieraona say, let's also be specific where we can if we have got practices. So I think all of these are great sensitivities.

Effie?

DR. CHOW: Actually, I didn't hear Charlotte use the word "belief." She used "principle." Tom's word is "belief." Okay. Everybody has been directing belief at

Charlotte.

[Laughter.]

DR. CHOW: I just want to protect you a bit, Charlotte. The thing is, I think "philosophy" may be a good word. I want to throw out "philosophy," "philosophy and approaches."

MR. CHAPPELL: May I hear from Jim, please?

DR. GORDON: My suggestion is, first of all, I think we are agreed that there are certain core principles that go with the practices, that we have to be careful, that that has to be part of the introduction, and we have to be judicious about which words we use when.

I also think, Tom, that you have taken us through this. We only have the fifth, the last item to go, and we really need to break for lunch, because this is only a couple pages of the report that we have gone through, and we have a significant amount still to do.

SISTER KERR: Wayne wants to use commandments so we can get faith in.

[Laughter.]

DR. GORDON: Wayne, is that a tactic or a strategy?

DR. JONAS: A strategy.

MR. CHAPPELL: Jim has called this to a covenantal issue here, and that is lunch. We thank you for everything.

Could we look at Item 5, Exploring ways to integrate CAM approaches and practices into national health and wellness initiatives.

Jim.

DR. GORDON: I mean, I am happy with dropping out for the entire population. I think this makes it general, and anybody who doesn't join in is going to be in big trouble.

I think this is a perfectly appropriate way. This certainly reflects the sentiment of what we have heard from many, many people as well as within the Commission, and it gives us a subject for debate. People can express their opinions, and I think it is something that will attract interest without being a mine for us.

MR. CHAPPELL: Any other comments?

DR. GORDON: Except perhaps a gold mine.

MR. CHAPPELL: Well, thank you all very much.

[Applause.]

DR. GORDON: Okay, so we are going to go to lunch. We will come back at 1:05, okay?

[Lunch recess taken at 12:28 p.m.]

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

[1:26 p.m.]

DR. GORDON: I want to make a point to the Commissioners and also to the rest of you who are here with us, to the public, that the discussions today and what we have up here, this is not the Interim Report. The Interim Report is what we are working on developing, and so that the critiques that are coming up, the additions, the suggestions, the debates, this is all preparatory to creating the Interim Report, and I want to make sure that everyone knows that the Interim Report has to go through a couple of more iterations before it is ready. So what is involved is pulling together everything that we have heard at this meeting, fashioning another draft which in turn will be reviewed by all of the Commissioners.

So the principles, perspectives, the concerns that have been raised, are helping to contribute to the creation of the Interim Report.

We will present the Interim Report to the Secretary of Health and Human Services on the 16th of July as planned, and it then, before it becomes public, it goes through a clearance process. And once it has gone through

the clearance process, the Secretary will present the report to the President, and the report will be available for Congress as well.

So I just want to make sure everybody understands that the drafts that are discussed here are just drafts. What is put up on the wall are simply principles that we agree to. How this is all going to be formed in the Interim Report is still to be determined.

Are there questions about that from any Commissioners? I wanted to make sure that was clear to both Commissioners and the public. Yes, Julia?

MS. SCOTT: So if I am understanding you, Jim, what you are saying is Commissioners are not responsible for releasing the report?

DR. GORDON: Right. The Commission is not only not responsible, the report goes from us to the Secretary, and once it has gone through clearance, he will release it. And the first place that he will be releasing it is to the President, and also he will be releasing it to Congress as well.

So until that time, this is still very much a work in progress. So thank you, Julia, for clarification.

Okay. Bill has to leave in a few minutes, so I wanted to give him a little chance to speak at this point.

DR. FAIR: Well, thank you. I distributed a brochure from our health center. Now this isn't what I think is ideal. All I can tell you, this is a result of one person's search for something that I can coordinate CAM medicine in my own problem, and I found out that, first of all, you don't know who is good.

Secondly, when you find that out, at least in New York, they are all over the area, and I was running back and forth.

And thirdly, and most disappointing, they don't talk to one another. So the way we have set up this is that each patient comes in, we have no physicians in the center, and that my role is simply the scientific validity of it, and basically we run it with nurses, nurse practitioners, and the person comes in, gets an evaluation by the nurse practitioner, and then goes and spends 30 minutes with a nutritionist and an exercise physiologist and someone in stress reduction and someone in movement therapies, yoga and so forth, and then after that we sit around in what I still call a tumor board. It's not a

tumor board, because we treat people who don't also -- it is not all cancer. But a case management discussion, where the approach is what is the specific diet for Joe, with his cancer, or Mary with diabetes, or whatever, and so forth, put together a program, and then if the client so wishes, communicate this with the person's physician.

I mean what we are trying to do is to keep the physician in the link, to communicate. The subtle message is also to educate physicians as to what CAM has to offer, and basically that it is an approach, we think of this as an extension of the physician's office, not we are the competition of the physician.

So, again, I don't mean this to be the only way to go. It is one way, and I just wanted to share it with you, because, as I said, it came out of my own search.

DR. GORDON: Thank you. Thank you very much, Bill.

DR. FAIR: Thank you for giving me the time.

DR. GORDON: Yes, I would encourage the Commissioners to take a look at the material, because this really comes out of Bill's personal search, as well as his understanding as a physician and surgeon. I think that is

a real power.

I also would ask other Commissioners if you have materials that you would like to share with us. One of the things of the nature of the Commission has been to ask other people to come and tell us what they are doing.

Obviously the people who are sitting around this table have also been spending their lives doing some very interesting and important things. So what we, I think, would welcome is if you want to share the work that you do and the perspectives that you have with all the Commissioners, if you would make available material -- I hope I am not speaking out of turn, because I haven't talked with Steve, but I am assuming that we can facilitate this.

If you want to make available the materials, we can make that available to all the Commissioners, so that we can have the benefit of not only each other's comments on the issues that are raised here, but also the benefits of seeing what your work is like. I think that would be very, very useful.

So, thank you, Bill, for leading the way in doing this.

DR. FAIR: I might also add that anyone else, I would just ask them to send me a bunch and it came out just about a bunch equivalent to the Commissioners, but if anybody else wants it, just give me a call or drop me a note and I would be happy to send it to you.

DR. GORDON: Thank you. Okay. It is time for us to move ahead. We have the majority of the Interim Report to go over, to discuss, as we discussed the wellness section, and what I would like to do is to proceed with the different sections, moving through them, and again hearing issues that are raised, concerns that you have, places where you think the tone may be off, and then moving from a discussion of the text to whatever recommendations there may be, if indeed there are any recommendations at the end.

Does that sound like a reasonable way to proceed with the rest of this? Yes. Okay.

We have approximately two hours to do this, so I am going to take the liberty of moving things along quickly so that we can make sure we cover all the sections and everybody gets heard.

Please, if somebody has made the point, and we

are looking for consensus, and everybody agrees, let's just agree, we don't have to have a great number of concurring speeches. In the interest of saving time, let's really try to be disciplined.

Discussion Session VI: Draft Interim Report

DR. GORDON: So let's start. We have had discussion already of the opening and the introduction. We have an outline and a sense of what needs to be covered, and the way it needs to be covered.

The pages 2 and 3 are basically -- and I note that on page 2, the fourth task of the Commission was somehow omitted, there is a typo. But basically page 2 and 3, and the Commission's progress to date are pretty much simply factual accounts of what has happened so far.

So I would like, unless there is some particular concern in those, to move right into a coordination of complementary and alternative medicine research.

MR. DeVRIES: Just a quick comment. Under V, Commission Membership, Sister Charlotte, you may want to check, because it doesn't have you specified as a licensed acupuncturist or as a nurse.

DR. GORDON: Well, thank you. If there are any

other errors in titles, please let the staff know about that. Thank you, George.

Dean, do you want to make any opening statement about the research section, since you have led the discussion and have been so intimately involved with it?

DR. ORNISH: Well, I guess I would just be curious to know if anybody has any changes that they would like to make based on what is here. We had a whole session on it, but now that we are actually getting down to the nitty-gritty, what are your thoughts? I guess we are on pages 4 and 5 now, is that right? Four, 5 and 6.

DR. WARREN: Remember that, on page 5, right after line 14, Wayne had something that he thought needed to be added there. Of course, he is not here.

DR. ORNISH: I think one of the things that we talked about was whether on page 5, line 12, the creativity and research methodology and flexibility in study design, whether we want to get into that level of being prescriptive, whether that raises issues of, is there something less rigorous about what we are proposing; would it be enough to just simply say that the research methodology should be appropriate to the approaches and

techniques being studied, and leave unstated the second part, which, again, it is an issue of being skillful in not pushing people's buttons early on.

I know this is a big button for a lot of people, the Marcia Angells and the Arnold Relmans, and others, that somehow CAM has a less rigorous approach, that it is more sloppy. There is no point in me even raising that issue if we don't need to, at this point, and save it for the Final Report.

Beyond that, I don't think I have any real suggestions. I think that this was very well written. I want to compliment -- I am not quite sure whether it was Corinne or Gerri, I guess it was Gerri -- for doing this.

I would be curious to know if anyone else has anything that they would like to have changed, based on what is here.

DR. FINS: Just one little thing, on page 4, where we mention the thousand speakers, we might want to make some mention of the folks we didn't hear from.

Then on the section that Dean was referring to, I think in the paragraph that ends on page 5, Safety and Efficacy, I think somewhere in there I would like to have

language about hypothesis generation.

DR. GORDON: Joe, could we take you back to the suggestion that Dean made? I would like to deal with that in an orderly way, about you raised the possibility of eliminating Number 2.

DR. ORNISH: Number 2, line 12, page 5. Then somebody mentioned, Wayne, that you had some thoughts you wanted to float, around line 15 on page 5, on the numbered document, on page 5, in between the paragraphs that end on line 14 and begin on line 16. They may be mistaken, but somebody said you might want to add something here.

DR. JONAS: I think what we were talking about is the importance of research being a tool for providing information to particular audiences for particular uses, and I think the phraseology I had suggested was research should be designed to provide the types of information most useful for those seeking delivery of CAM services. It is an issue about prioritization.

DR. ORNISH: Would you be comfortable if we added to that a line something like, "using the most rigorous and appropriate scientific method" or "scientific design"?

DR. JONAS: Well, we actually have another section that deals with rigor and that type of thing, which I think is important, and there would be some easy ways, when we get to that, to addressing that.

DR. ORNISH: Well, I am just trying, again, to avoid pushing people's buttons.

DR. JONAS: I agree. I would like the idea that research design, selection of the research design, needs to be targeted towards the type of information you want your audience, that is going to use it. Within each of those research designs, you should use the best and most rigorous science that you can use, and that should definitely be stated in there. That was already stated in a different section.

DR. ORNISH: Towards the audience or towards the question?

DR. JONAS: It is towards the question. You select the design and your goals, based on the type of information that you want.

DR. ORNISH: Right. Okay.

DR. JONAS: From that, then you put together the best, most rigorous methods to achieve those goals.

DR. ORNISH: Well, I think, maybe, to make it even less questionable, just say that based on the hypothesis that is trying to be answered -- Corinne, you look like you want to say something.

MS. AXELROD: Yes. I did want to say something. Where it says, "the studies need a focused question," line 9, I had originally written, "studies need a clear hypothesis," and I changed it to "focused question" because I thought that actually broadened it. The word "hypothesis" is very conventional.

DR. ORNISH: Well, why don't we do this? I mean, again, my goal is to try to have us be as skillful as we can, and when the Arnold Relmans and the Marcia Angells, and the others who are just waiting for us to mess up, read this, they say, well, I am glad we got through to them; I am glad they listened to me.

So if you say the studies need a clear hypothesis, a good study design, and then leave out Number 2 on line 12 through 13, we can always elaborate things on the Final Report. I think this will pass muster with them and then make them allies, or at least neutral as opposed to giving them an easy target and it sounds sloppy to

them.

MS. AXELROD: All right. So basically, the "clear hypothesis" which I originally had, plus the "focused question" in parens.

DR. JONAS: Let me just modify that a little bit. I mean, because there are very important and very rigorous types of studies that explicitly do not do hypothesis testing and generate hypotheses. They are extremely important types of research, and often get at the more relevant issues related to what the patients want. So it is important that we not make a blanket statement about all types of research as a general aspect.

This is why I suggest that there be wording in there that you need to do high-quality research, and that research needs to be appropriately designed to answer the types of questions that you need for the type of information that you want, or the audience that you want. We can rephrase that.

So I think the issue is that we need to use high-quality science, we need to use the best methods and methodology for answering the research questions, obtaining the type of information that we need, and that

can be a blanket statement.

To say, then, that everything should be hypothesis-generated ignores one area. Now, you can say that you need to have hypothesis-driven, hypothesis-generated research when you are seeking cause-and-effect relationships, for example, in clinical trials, which are trying to make statements about attribution. Then hypothesis generation is clear.

When you are trying to look at mechanisms, for example, you have to do hypothesis generation. That is the whole basis for basic studies, is the hypothesis. So I don't want to go into the details, but what I am saying is, that you can use a phrase like high-quality research -- okay, science, the best evidence for obtaining the most relevant information, and this type of thing.

DR. ORNISH: I can go with that. Highest quality science to obtain the most relevant and useful information. That is perfect.

DR. GORDON: One point I want to make, though, is, we need to remember who our audience is. So "highest quality science" is fine. We don't want to become obscure. This is for lay people. Even though the

scientific community will read it, it needs to be completely intelligible to our primary audience, otherwise, we will lose them.

DR. ORNISH: Well, I don't think there is anything unintelligible about "high-quality research."

DR. GORDON: No, but when we start talking about "hypothesis generation," I am responding to that. I am just laying out a thought for future discussions.

DR. ORNISH: Okay. Well, that is why I thought putting both in would be useful.

DR. JONAS: I mean, "hypothesis generation" is a little too esoteric, I think, in this area.

DR. ORNISH: Let's not get bogged down in this. I was saying you can say "hypothesis," paren, "focused question," closed paren, so that it is clear to everyone.

MS. AXELROD: I was just going to ask whether it would make sense to say "clear hypothesis" or "hypothesis-driven," or something -- I would have to play with it -- or "focused question," because in any study you have to have a focused question, whether or not it is a hypothesis. It is a question.

DR. ORNISH: I don't want to get bogged down in

it. If you could just put "hypothesis," "focused question," it is going to be clear to everyone. It is going to be an Interim Report.

The main thing I am concerned about is the people who are waiting for us to slip up. This is exactly where they are going to be looking for it, and we won't be making ourselves vulnerable to that. That is all. That is my primary concern here.

MS. AXELROD: Okay.

DR. FINS: It is in the same section, but on line 10, before "research." Can we say "qualified research"?

DR. ORNISH: Sure.

DR. FINS: Well, "qualified," has different meanings.

DR. ORNISH: Yes, that is good.

DR. FINS: "Qualified." I mean, we had that whole thing yesterday about the Nuremberg Code. It relates to that. So, "qualified."

DR. GORDON: Where?

DR. FINS: Right before "research."

DR. GORDON: There is no "research" there.

DR. FINS: Line 5.

DR. GORDON: Oh, 5. I'm sorry. Okay.

Wayne, go ahead.

DR. JONAS: I just want to make one suggestion, and I don't know if I want to go into wording here, but we did this in the development of the center work.

What we want is a variety of types of research, and we want good research in all of those variety of types. So you can actually list the main ones. We talked about them: outcomes research; health services research; randomized control trials; basic science research.

My suggestion is that what we put in here is a paragraph which says that it is generally agreed that research of high standards and study design and execution is required. This includes a variety of research types that address the needs of those seeking delivery in and understanding CAM services and products. This includes, and then you can say randomized control trials, health services research, outcomes research.

DR. FINS: I wouldn't use the word "needs," because it sounds like we are tailoring the methodology to the physician. I would just stay to the question, again,

not the needs.

DR. JONAS: The question is derived from the need, right? I mean, you design your goal based on the type of information you want, and the type of information you want is based on how you are going to use it, and how you are going to use it is what you need.

DR. GORDON: Let me say there there is a difference here, and the difference, I think, has to do with whether research is directed by the needs of the people for whom one is doing the research, or whether it is driven by questions that arise from science or the state of the science, or the science of an establishment. I think that is a difference. I don't know if it is real or apparent.

DR. JONAS: It is not an either/or. This is not an either/or. In fact, you don't have to use the word "needs." I didn't actually use the word needs in here: "Provides type of information most useful for those seeking the delivery and understanding of complementary and alternative medicine practices." I didn't use the word "needs."

DR. FINS: How about if we said the most

information necessary for delivery of safe and effective CAM modalities or something?

DR. JONAS: I think that is okay, except then that eliminates understanding, which is a basic science question. So I mean, it is inclusive. I am not saying that we do either/or. I think it needs to be inclusive. And then if you list the major types of research that you think need to go on, basic research, health services research, outcomes research.

DR. ORNISH: I think all of that is good, I like that. And again, what I am really trying to avoid, and what they are going to be gunning for, is anything that gives the appearance that there is a different quality of research or a different level of science or a different standard, and nothing that you said really pushes that button.

DR. JONAS: I agree. And, in fact, if you want, and I would be happy to do this, I could word this in a way where it is absolutely razor-sharp in terms of saying science is, you know, following our principle number whatever it was, 2, that is up here, that science is the absolute, I mean we believe that science is the important

tool for doing this.

DR. ORNISH: Well, I have complete confidence in you, Wayne, so why don't you do that?

DR. GORDON: Let me check in with everybody else. Is everybody else comfortable with that, too? Wayne, do you want to say what you are going to do, then, just very quickly? Does everybody understand? That is okay?

DR. JONAS: Yes, I will just put a paragraph in here that emphasizes the importance of science and science is the basis for understanding complementary medicine and its delivery, and that includes type of research, high quality research and the types of research design that is needed to do that.

DR. GORDON: Okay.

DR. JONAS: And list the basic ones that have been discussed in the last few weeks.

DR. GORDON: Okay. Everybody comfortable with that, then?

[No response.]

DR. GORDON: Good. Dean?

DR. ORNISH: I think it is great. I guess the

last part has to do, on page 6, in lines 7 through 17, were there any concerns that people had? Well, actually even on the previous page, beginning at line 23. I am trying to remember whether there were any concerns that were expressed about that.

DR. LOW DOG: I was just wondering if Wayne was sort of going to be taking in that outcome study and this, if that may actually end up sort of replacing that, because you are going to word into this, right?

DR. ORNISH: He will weave it into that.

DR. JONAS: This is slightly different. Actually, Dean, I will send this to you so you can look at the phraseology of all of these items and then you can circulate them among anybody else that you want.

DR. ORNISH: Good.

DR. JONAS: But I think that the issue here in this paragraph is that we want to make sure -- there are agencies that already do other types of research and that have it as their main focus, and so we should put that in there.

One suggestion I had is that we stick in, for example, after agency for health care research quality or

key to research progress, that it is clear that similar support and coordination efforts are needed in other federal research agencies. Okay?

So, in other words, we talked about the success of the NIH's effort in these areas and some of the other agencies, and we should put a statement in there simply saying we like this trend, we think other agencies should be involved in this, so we recommend providing similar support in other federal research agencies.

DR. ORNISH: But would you say in all of them?

DR. JONAS: Excuse me?

DR. GORDON: Would you turn on your mike, please, when you speak?

DR. LOW DOG: Sorry.

DR. GORDON: He is on page 6.

DR. LOW DOG: I thought that where we were at -- okay. I was in the wrong place. Go ahead. I was on page 5. I thought Dean had us between 16 and 23, and I was just saying is that part of what you were doing?

DR. JONAS: Yes, exactly.

DR. GORDON: Yes?

MS. AXELROD: I have a question then. The

outcomes, you will be replacing this reference to outcome studies. But what about the sentence that starts with anecdotal reports? Are you going to replace that as well, or does that remain?

DR. JONAS: Yes, I think we can weave it into it, yes. Okay.

DR. ORNISH: It is going to be woven into it. And I apologize for skipping around here. So that takes care of 16 through 21. Lines 23, on page 5, through line 6 on page 6, any comments about that? Any changes anybody made?

DR. JONAS: I had one general question as to whether we wanted to say anything about -- this is a land mine, so maybe we should put it off for later -- patents, along the lines, or something along the lines of incentivizing investment in private research into these areas. Whether we say it is patents or not may be debatable, perhaps leave that out, but some phrase about the importance of incentivizing private sector research.

DR. GORDON: Are you referring to the sentence in funding initiatives for studying unpatentable products? Or are you referring to something else?

DR. JONAS: Yes. What I am suggesting is that we also add in there that we would like to see incentives for correcting this problem, which is lack of incentives to fund research in these areas.

DR. GORDON: I am wondering if we shouldn't wait. The way we have it is general. If we can wait until we really develop specific -- I would rather wait until we have specific recommendations on that, rather than go out sort of halfway with it.

DR. JONAS: Okay, but wouldn't you agree that it is important and we would like to try to incentivize the private sector in investment in that? That is what I am suggesting.

DR. ORNISH: Why don't we make it in the most generic terms, just like you said, encouraging the private sector to invest in CAM research.

DR. JONAS: This is sort of negative. This is like, well, nobody is going to invest in this area.

DR. ORNISH: Yes, I think that is a good idea. So, Gerri, can you just add some language to that effect, or Wayne, when you e-mail me, can you just put that in there? I like that.

DR. GORDON: Say it again, and let's make sure.

DR. ORNISH: It is saying to encourage the private, on page 5, line 27, something like encouraging the private sector to invest in CAM research and delivery.

DR. GORDON: But that is in addition to what we have said here.

DR. ORNISH: Yes.

DR. GORDON: Okay. So is everybody clear that there is a distinction here, that there are two initiatives that we are talking about? One has to do with encouraging public research funding for those approaches that can't be patented. And then this is in addition, which is having incentives for people in the private sector to --

DR. ORNISH: No. We are not getting into that. It is a red flag. We are not saying we want to offer incentives. We are just saying we want to encourage the private sector to invest in CAM research.

DR. GORDON: But I am just saying those are two different topics.

DR. ORNISH: They are two different topics. One is a red flag, when you talk about --

DR. GORDON: No, no, no, those are not the two I am talking about. One is public investment, and the other is encouraging private investment. Okay?

DR. ORNISH: I am only saying we are going to encourage private investment, that we don't put incentivizing in. That is all.

DR. GORDON: Understood. Okay.

MS. AXELROD: On page 6, 19 through 21, does talk about federal agencies -- wait. Private sector, rather, I'm sorry, including foundations, manufacturers and pharmaceutical companies. So that is private sector. Where do you want to put the addition you just made? Do you want to put it there, or do you want to put it --

DR. ORNISH: It goes better there, you are right.

MS. AXELROD: At the end?

DR. ORNISH: Yes.

MS. AXELROD: Add it there?

DR. ORNISH: Yes.

MS. AXELROD: Okay. Okay.

DR. ORNISH: Encourage.

MS. AXELROD: Encourage.

DR. GORDON: Okay. I want to say just one word on process. We need to move quickly, but if people are confused and don't understand, please, you know, raise your hand and say so, and we will try to clarify it as we go.

DR. ORNISH: Yes, just in the interest of process, if we could just agree that the burden of responsibility is on you to jump in and say I don't understand, or slow down, or, you know, I don't agree with you. And the silence is taken as an assent.

But I do have a problem on line 19, on page 6, when you use the word required. I would say encouraged. ON page 6, line 19. Adequate support for CAM research is not only required, I would say encouraged, to avoid pushing people's buttons, because then you are basically requiring the private sector foundations, et cetera, to do these things.

You know, what we haven't done is the previous paragraph, line 7 through 17. Any comments, suggested revisions, problems?

DR. FINS: I have just a generic question, and this is not the level of specificity here, but the

question is what do we mean by strong support? How much against what? You know, do we have to justify this in the context of a current allocation to NIH? Is it additional money? Because I think that will be, you know, a red flag.

DR. ORNISH: You want to just take out the word continued? Or are you saying the other direction?

DR. FINS: Well, I am asking the question, you know. And the other issue which has been brought up on other occasions, whether or not NC CAM is -- we all agree that that is the entity that we are seeking to maintain and support, and whether or not there is language about fostering even more collaborations with the other institutes.

Can we state it stronger, like to -- I think some kind of language that just, you know, stresses the importance of enhanced collaboration. I mean recognize the current existence of collaboration, but that we believe that to bring the basic science talent, which --

DR. ORNISH: But lines 12 through 14 address that. You want to reword that in some way?

DR. GORDON: I will tell you my problem, which

is related to this, is I don't like the passive voice. I think this has got to be more active. Passive voice always comes off sounding weak, no matter what you are saying. So I think we need to make these statements, and I think it will clarify our intention if we make the statement in the active voice.

DR. FINS: Encourage. You know, we recognize collaboration between NC CAM and other NIH research institutes, and we encourage additional collaboration, especially with their basic science colleagues at the NIH. I mean that sort of language, and that is the intent.

DR. JONAS: Yes, I guess I wouldn't highlight a specific thing that we think the NIH should do with its own colleagues. I would be a little bit hesitant of that. I do think we should put something more strong in there, and I mentioned this before, but I will say it again, is that, right before -- and I wrote this. I didn't write it on the numbered thing because I didn't get that until yesterday -- but right after the Centers and Agency for Health Care Quality and Research is key research.

Just before it, during the testimony, the importance of CAM-associated activities, we should put in

a phrase that is stronger, that is, it is clear that a similar support, meaning similar to what has gone in already to the NIH, and coordination efforts are needed in other federal agencies.

DR. ORNISH: But then aren't you doing the very thing that you are saying we shouldn't be doing, which is dictating to the NIH what they should be doing?

DR. JONAS: I am not dictating this to the NIH at all. I am dictating this to the Congress and President, that they should do this with all federal agencies.

DR. GORDON: I think, Dean, this response to your question and concern about red flag, I think we have to come down, if we believe that more research funding is necessary, we need to say so quite clearly.

DR. ORNISH: I don't have any objection to that. I actually support it.

DR. JONAS: And I do want to put in, I do think we should say something about basic science research in there, and I guess --

DR. ORNISH: I like that, too, and I think that is only going to make our case stronger with the people

who are going to be our most vocal critics.

DR. JONAS: I would suggest actually it go up above after safety and efficacy on page 5, line 21, that we simply add another phrase in there that emphasizes the important basic science research, such as an effort to investigate the underlying mechanisms, assumption of CAM modalities is also needed.

DR. ORNISH: That is good. Gerri, are you okay with that?

DR. CHOW: Yes, I want to say that this is still coming from the voice of the people, and I agree, we need to be strong. Whereas we can't change the strength of what the people are saying because we are afraid of land mines, and it isn't us that are stepping in land mines. And so I just want to bring that out again because we are afraid because we think it is coming from our mouths, and it isn't, it is coming from the people's mouth.

DR. ORNISH: Well, let me just clarify, as someone who has been the most vocal proponent of that particular concern, I am not afraid of this. I am only trying to be as skillful as we can in not getting shot out of the water before we begin. I think all the things that

Wayne and Joe and others have proposed I think actually makes this stronger. I don't see any land mines in the things that they talked about.

So it is really a non-issue, but in general, it is not a question of being afraid or whose voice it is. It is really a question of being skillful.

DR. GORDON: But I would add with Effie that it has to be clear it is both the people's voice and it is our voice, and that we are reflecting the people's voice.

DR. ORNISH: Well, then maybe we need to say that at the very beginning, because that would apply throughout the document, something that this is a synthesis of the testimony that we have heard, in addition to our own perspective, or something like that, because it is important for the reader to know who is speaking, and who they are speaking for.

DR. CHOW: Excuse me. It is in here.

DR. ORNISH: But I do think we have to be careful that since we have heard so many diametrically opposing points of view, that we are not necessarily speaking for all the people, because if we were, that would be impossible.

DR. GORDON: Wayne?

DR. JONAS: I have a suggestion as to how to do this. I think it is important. It is one of our six principles, Number 6, actually, up here on our principles. My suggestion is again there is a very simple way to do this that I don't think would raise a lot of land mines, and that is under page 6, Item 17, to simply add a phrase to that effect, Effie, such as procedures for the more effective input of public interest and priorities in research are needed.

DR. GORDON: Great. I like that.

DR. JONAS: Does that sound all right?

DR. ORNISH: In a way it extends what Effie was saying, that we are speaking for the public here, but we are encouraging the people to make their voice heard. I like that.

DR. GORDON: I would like to call time, unless there is a major sticking point, because we really need to move on to the next section.

DR. ORNISH: This is a process, Wayne, where you are going to send me an e-mail that incorporates all the things that we talked about, and a copy to Gerri? And

Gerri, who is going to do what first, just so we know?

DR. JONAS: Why don't you modify what we talked about?

Gerri, send it to me. I will send it back to both of you, and then you can do whatever you want with that.

DR. GORDON: Let me just say that any emendations that we make, this has all got to move very fast, okay? So if anybody is being asked or is taking on the responsibility of doing a piece, it has to come to the staff within a day or two at max. Okay?

Thank you, Dean. Are we okay now to move on? Regulatory activities. Tieraona, do you want to move with this?

Regulatory Activities: Research

DR. LOW DOG: So we are just starting where we left off there, on page 6. Again, this is where we are looking at the whole discussion about dietary supplements, primarily.

Comments? I will give you a minute to kind of look it over.

DR. JONAS: I would just like to make one

general comment about it, is, I thought a lot of it could be condensed. It seemed like sections of it were kind of redundant. We were saying things more than once.

For example, starting with line 15, those two paragraphs, I had the sense that those had been stated in other ways, and I would just suggest that you look back through this section and maybe see if you can condense some of those. Page 7, starting with line 15, those two paragraphs, I am not saying eliminate them, but I am saying that they could be condensed.

There is another, the paragraph on public testimony, the end of that, also, again kind of reiterated the same idea about supplement quality, et cetera, et cetera. I mean, the point is that we want good quality supplement aspects, and we don't need to say it three times, if we could say it once.

DR. GORDON: So basically, this is an editorial comment, not a context comment?

DR. JONAS: Exactly.

DR. GORDON: Okay.

DR. CHOW: Wayne, I am not clear about the two paragraphs. The one starting on line 15, and then the one

on 22?

DR. JONAS: The two paragraphs starting on page 7, line 15 through page 8, line 3.

DR. CHOW: Okay.

DR. JONAS: And then the end of the paragraph, starting on page 8, line 25. Those two -- those three paragraphs seem to have a lot of redundant material in them, and you might just look at condensing that.

DR. GORDON: Thank you. Michele's hand is up.

DR. LOW DOG: Michele?

MS. CHANG: Yes. We had talked a little bit about wanting to be positive, to acknowledge the good things that agencies or organizations have already done. One of the things that we heard testimony on was from the FDA to say that they have made headway along the lines of developing these good manufacturing practices and guidelines, but they are just not out.

So it has kind of gone in and out of this version as to whether or not we should make passing reference to the fact that FDA has done something that the public is calling for, that everyone wants, and yet it hasn't been seen yet.

So, again, to kind of walk that fine line between not getting squelched --

DR. LOW DOG: I think we really want to put in there, though, they need to get those GMPs out. They have been sort of keeping those things for quite a while, and the industry is waiting for them. So I think there needs to be the recommendation that they pull those GMPs out.

I think, also, just for clarification on lines, when we get to 23, 24, and 25, the FDA's regulations on GMPs, where you are talking about accurate labeling, that is not a GMP function there. So you just need to separate those out, GMPs and what they deal with, and be clear what they are. A lot of people are not clear what those will do, but that is not about your labeling.

You want to separate that out, that labeling is important and that the FDA needs to make sure that companies are in compliance with DSHEA structure and function claims on their labels, that they need to meet the requirements that have been set out in DSHEA.

Yes?

MS. MILLER: I just want to add to what Michele said, just for a little clarification. The GMPs are out

of FDA. It is the Office of Management and Budget that they are not out of. So it is not FDA that is holding it up, it is OMB right now.

DR. LOW DOG: Can we also be a little bit more specific where we are talking about method validations, where we are talking about needing to support programs that are developing, methods?

DR. GORDON: Tieraona, where are you in the text?

DR. LOW DOG: Well, it is kind of down here on 28 and 29, page 7. We use interesting language like "standardizing the identity and purity." "Standardization" is its own term in this category. I would be more clear that methods for identification, standard methods and characterization, need to be done because we only have them for a few herbs.

DR. FISHER: The operative word is "compositional quality."

DR. LOW DOG: There you go, Ken.

DR. GORDON: Okay. Now on this, if there are those kinds of technical issues, it is important that that be conveyed either here or afterwards, between you and the

staff.

DR. LOW DOG: Who is the staff person that did this? Okay.

Well, can part of it be where just the staff and I could talk?

DR. GORDON: I think you just need to let people know where that is going to happen and get a general assent that that is fine, and then you can do it.

DR. LOW DOG: Right.

DR. GORDON: Okay?

DR. LOW DOG: Well, I will do it tonight on the plane, and then I can just e-mail it to you, and then it can go around to anybody. But I think it is all very good. I think there is some redundancy, and I think some of the language is a little confusing when you use standardization and you use other things. So I just think we can tidy it up.

DR. GORDON: Okay. Xiaoming?

DR. TIAN: I think for this paragraph, I feel the tone is tight or connective because this regulatory research, page 6, mentions GMPs. They have so many problems, but it is my understanding the majority of this

population that take dietary supplements do not have problems. The minority, only a few problems should be addressed. We have plenty. We mention here plenty, right?

Should we put a few sentences to give an impression that, generally speaking, dietary supplements are safe and people are using them?

Otherwise, we see all the problems. Mention that dietary supplements do not meet GMP. GMP is for drugs. We are not talking about a drug, we are talking about the dietary supplement. So there is no such standard.

Must everything meet the standard as a drug? Which is impossible, especially for all the small factories that can make that.

DR. GORDON: Steve, do you want to respond?

DR. GROFT: Ken is going to.

DR. FISHER: I was just going to correct that. As Corinne said, they are waiting to be vetted in OMB, but we can't say that. What you need to say is, and it practically says it, the way it is written, there is a need for good manufacturing practices for dietary

supplements. That will get the message across right there. There is no use pointing a finger at who is holding it up.

DR. LOW DOG: There will be GMPs. There will be GMPs, and the GMPs are actually under food for now.

DR. TIAN: Not yet.

DR. LOW DOG: No. There are GMPs because they are dietary supplements.

DR. TIAN: No, not yet. There are small companies, they have a license to make that. They don't need a GMP to sell the product.

DR. LOW DOG: Yes. That is right, a small company.

DR. TIAN: It is high-quality check, with this issue, with the FDA, and there is no need because that is the qualification for the drug. For each state that they have license, they have to meet the license. They have to go there to the state level. They will check all the factory, if you want to produce any product.

So if we had to meet GMP, I am afraid there probably is 10,000, maybe more than 10,000 small factories that cannot make products.

MR. FISHER: Ming, you are correct when you refer to drugs. You probably got an answer from the drug side of the house, but there are GMPs on the food side of the house, as well as standards of identity, and now in the mill are basically good manufacturing practices for supplements, and that is what has not yet been publicly available.

So you are correct for drugs, but this is something on the other side of the house.

DR. TIAN: In the future.

MR. FISHER: Well, it should have been about three or four years ago.

DR. TIAN: Well, it is still in the future, right?

MR. FISHER: Yes.

DR. TIAN: Whenever it is available --

DR. GORDON: We need to move along.

DR. LOW DOG: Joe, do you have a comment?

DR. FINS: I'm sorry I missed a little at the beginning of this conversation, so I have some other comments when you are done with this section.

DR. LOW DOG: Okay. I think one of the

proposals made was about putting a positive spin on it. I do think that that is important, that many companies are trying to do good quality, and that there is a huge consumption of herbs, and that there have been problems identified within the industry, but I think we probably want to put that in a realistic perspective instead of just, this is a renegade industry and everything is in disarray.

DR. GORDON: Yes. I think that the other thing that perhaps needs to be even stronger than it is here, is that the companies have been active in promulgating GMPs.

DR. LOW DOG: Yes. So all of those things, I think, should set the tone for this, looking for maximizing the benefit and the optimism of these.

DR. FINS: One of the things we talked about yesterday is that this is a consumer-driven movement. Consumer protection is part of the enfranchisement of being an enfranchised consumer. I think that in this area, under the second paragraph of the section -- what page is that?

DR. LOW DOG: Page 7.

DR. FINS: Page 7, right. Okay, got it. There,

I think we need to mention explicitly the Blendon study about not withstanding the interest in access and dah-dah-dah-dah-dah, a recent study also demonstrated a desire for increased regulation, maintenance of safety, et cetera, et cetera. So it is balanced. We have a parity between access, consumer-driven, and consumer protection at the same time.

DR. GORDON: Just one point about the Blendon study, there was even more interest in having access.

DR. FINS: Right, right. I mean, the paper said it, exactly. That is the point, access is something that is not safe, it is not an access that we want to foster. I think, at the same time, we don't want to leave the impression that all this stuff is very dangerous. I think we want to be balanced. I think Blendon works very well in that context.

DR. JONAS: Principle 3: Accountability and access must be linked. I had a sentence that I did not understand at all. I couldn't understand it after reading it, and this is on page 8, the paragraph that begins with page 5, in this last sentence that starts on line 9, 9 to 13.

"To accomplish this, current AER systems must be strengthened by both the private and public sectors, and outreach activities to communicate to CAM and conventional health professionals and consumers the importance of AER, of CAM products, must be improved."

I don't understand that. Is that a --

DR. GORDON: Well, Wayne, you know why? You have got two sentences there, to begin with.

DR. JONAS: Oh.

DR. GORDON: So it makes it a little more difficult.

DR. JONAS: Is there a period somewhere in between there?

DR. GORDON: There should be.

DR. JONAS: Oh. Okay, well, maybe that could just be rewritten.

DR. FINS: It is the German reporter.

DR. JONAS: It is the German reporter.

[Laughter.]

DR. FINS: Right here, I think it makes sense to mention explicitly the OIG report.

How do people feel about that? Because it

really is adverse event reporting. It is recommendation that is out there. I think it is very prudential. How do folks feel about that? It would go here, I think.

DR. LOW DOG: So the Inspector General?

DR. FINS: The Office of the Inspector General.

SPEAKER: Also, there are two GAO reports on this topic as well that I think might be helpful.

DR. LOW DOG: I think where you can put some data, where people have actually looked at this, I think it is important to build some data into this report.

DR. GORDON: Let me just say something. We have three more minutes for this topic.

DR. JONAS: I mean, like we have said with other topics, we really need to contextualize this within the current ongoing efforts on adverse event reporting and safety, and that kind of stuff, and say CAM should be included in those as an important area to address.

DR. FINS: We could say, constant with the efforts of the OIG's report, we endorse increase vigilance for AERs.

DR. ORNISH: When I was just outside taking a phone call, somebody came up to me and said that there

were a number of things in here that he is concerned about, that are inconsistent with some legal things that are out there now, and suggested that we have an attorney who is well versed in this area take a look at it so we don't look foolish.

So I am just being the messenger here.

DR. LOW DOG: Right. We are aware that there is some real stuff in here. We are going to clean it up.

DR. GORDON: Charlotte?

DR. LOW DOG: Oh, Charlotte, I am going right to you. George has been waiting.

SISTER KERR: Oh, sure.

DR. BERNIER: On page 8, the first full sentence, I don't understand. That is, "In its consideration of these global issues, the efforts of the World Health Organization will be reviewed by the Commission."

DR. TIAN: I don't understand it either. What material are you asking me to review?

DR. GROFT: That would be the report that we are awaiting from the World Health Organization on botanicals, I believe it is, that we have been in touch with.

DR. BERNIER: Well, it ought to precede this item, because I think it sort of stands alone.

DR. GROFT: Okay.

DR. LOW DOG: It is kind of vague. You are not clear what it means. So that is kind of an editorial comment. The sentence, it is unclear what it means.

DR. GORDON: I think you are right, but the previous sentence describes what the issues are, and then this one is hanging out there a bit.

DR. LOW DOG: Charlotte?

SISTER KERR: Mine is probably an editorial request. I keep thinking of this more and more as a teaching tool for the great population that will read it.

When you think about how you wording things, can you think of it as a teaching tool or user friendly as much as possible? Like Wayne's paragraph, I really think is a teaching paragraph in the research. What you are saying, even the different language, the AER, that really is for the beginner and the consumer and the legislators.

DR. LOW DOG: The congress people.

SISTER KERR: Thank you.

DR. LOW DOG: Okay. Good point.

Joe?

DR. FINS: The same section, but a different theme, on page 9, sentences 11 through 20 or so. We are talking about research regulation, and I want to say something here specifically about the need for adequate informed consent, protection of human subjects.

Then this verb really bothers me, "navigate the IRB process." It sounds like you want to navigate around, and that is certainly not what we want to imply. You want it to be consonant with the highest ethical principles and standards, and I think that needs to be explicitly stated.

DR. GORDON: I think the intention there was what was testified to by a number of practitioners who said they needed help with creating an IRB or working with an IRB. So your point is well taken. That was the intention of the statement.

DR. FINS: Yes. Good.

DR. JONAS: We also heard individuals say that IRBs need help in knowing how to handle and deal with CAM proposals.

DR. FINS: Talking about contextualization, I think we want to mention Greg Kosky's [ph] office and the

Office of Human Research Protection, the important work that that office is doing consonant with that effort, et cetera.

DR. JONAS: And the efforts, really, to revise the whole look at the IRB procedures and membership and that type of thing, which is currently going on now, stimulated by an entirely different area, but still directly related to this.

DR. GORDON: How much of this do we want in this paragraph?

DR. LOW DOG: I am not attached to the navigator or working with it, but I think whenever we can give a positive example of what is being done now and what is out there to feed into this, wherever you can support it with data, and wherever you can support it with what is actively going on now, I think it gives credence to the argument, I think it gives credence to the recommendation.

So if there are a few sentences that go before this that would indicate how this is already being done or who is doing it, I think it just gives the recommendation more strength.

DR. GORDON: I would agree with that. I think

the issue here is, how much do we want to talk about the IRB process in here. I think that we need to make a general statement. It is something we can go into, including all, as Wayne is suggesting, all of the complexities of dealing with IRBs on both sides, or all sides. That has got to come later. I think we can indicate it, but not go into the detail here.

DR. FINS: I think the generic statement about adhering to ethical standards, informed consent, protection of human subjects.

DR. GORDON: I would also say collaboration between the CAM and the conventional world in developing IRBs is crucial.

DR. FINS: Right. I think because otherwise it is not completely informed, and that it makes informed consent impossible.

DR. LOW DOG: One other issue, just in this section. Is there a reason why we sort of shied away from making some sort of recommendation, that, also what we heard was that DSHEA be fully implemented? Is there a reason why we sort of just didn't say that?

Because if you read this, one could question if

we are questioning DSHEA or suggesting that it somehow be reworked, and I don't think that is what we want to do, but we never, in here, say anywhere really that DSHEA should be fully implemented.

DR. GORDON: I think you are right. I think we should say up front and clear DSHEA should be fully implemented.

DR. FINS: That's right. Also, I think the other issue is, fully implemented, and then it should be evaluated, and then the appropriate oversight should go back and revisit this.

DR. LOW DOG: George.

MR. DeVRIES: My concern is, in terms of DSHEA, I think we should stay away from criticism or review of the law. I think we should stay focused. A lot of thought was given to it. It has not been fully implemented. Our position should be fully implement it.

DR. FINS: Can you say fully implement it, and then have it evaluated after an appropriate interval?

MR. DeVRIES: Why would you go there? We don't say evaluate the FDA in their function.

DR. LOW DOG: I understand Joe's point, though,

because a lot of times there is some sort of accountability or evaluation for lots of things we set into place. I don't think we need to do that in the Interim Report, though, but I do think we need to come out -- I thought we had consensus on that, that DSHEA should be fully implemented.

DR. GORDON: We do have consensus on that. We need to say it clearly, and I believe we need to say with adequate resources to accomplish this.

DR. LOW DOG: Well, especially if part of the purpose of this Interim Report is for them to get their budgets in line for what there might be money needed for.

DR. GORDON: Exactly.

DR. LOW DOG: This might be something they should be aware of.

DR. GORDON: Tieraona, we are going to have to stop here. I think we have covered just about everything, so let's move on to the next section on training and education.

Joe, do you want to guide this one through?

DR. PIZZORNO: Yes. I wish we had covered this area yesterday before we had this conversation this

morning, because I think we might have been more willing to be a little bolder about following through on some of the conversations and recommendation we had gotten.

When we look at the content here, while I want to give everybody a chance to think about it, in reality, I think there is actually one word that probably caused us some problems, and that was the use of the term "parity."

Now, I like "parity" in here. I really like the way the staff wrote this up. At the risk of furthering our discussions, I would like to suggest that we continue the language as written here and not change. However, I realize that there may be some who disagree with that.

MR. DeVRIES: Didn't we talk about more of an incremental approach and the concept of equal access, I think, Sister Charlotte or somebody was advocating?

DR. ORNISH: I still have the same concerns that I expressed yesterday, so in the interest of time, I won't repeat them, but I think, again, we want to just hold, again, what is appropriate for Interim versus the Final Report. I think "parity," you just might as well write "land mine" on it.

DR. PIZZORNO: You know something, you are

right. I withdraw my last futile effort. I want you to know that is just for the Interim Report. I am coming back for this for the full report.

[Laughter.]

DR. PIZZORNO: So anyway, the use the language we used from the discussion yesterday, I suggest it be changed. I will leave it to the staff to change it, but the language we came to consensus on was, "Provide access of accredited or licensed CAM professions, educational institutions, and practitioners to educational training, funding, and other resources."

DR. FINS: Would it be helpful, just to save time, to kind of recapitulate what we said yesterday about this section, so that we don't have to wordsmith all over again what we agreed to yesterday.

DR. PIZZORNO: I will just read to you what we agreed to yesterday. So that was one thing we agreed to yesterday, and the other one we agreed to, we agreed to Number 1. Number 3, we modified it to "Encourage and support joint- and cross-training of CAM in conventional health professions in undergraduate and graduate programs."

So I just want to say, this is the language we came to yesterday. I think we should say to the staff take a look at --

DR. FINS: The cross-training was one theme, that you weren't going to cross-train me to do what you do or vice versa, but I needed to become aware of what you do and vice versa.

DR. PIZZORNO: It was training together.

DR. FINS: But we got rid of cross-training because it implied all competencies.

DR. GORDON: Training from the lexicon here.

DR. PIZZORNO: Yes, and actually, as I think about it, we left it to the staff to work on it. The idea is that we would train together, not to learn each other's skills, but to be comfortable in working together. So we are going to leave the staff to work on some of the language.

So yes, thank you for that clarification.

DR. GORDON: Do you want to go over some of the other areas of agreement and see if there is anything else that we do need that we did not address yesterday, because we did a pretty thorough job that we need to attend to

her.

DR. PIZZORNO: Well, I think that what is written here is consistent with what we discussed yesterday, except for being clear about what cross-training actually means, and removing the word "parity." I read through this, and it looks pretty consistent other than that, but how about if others take a look and see if anybody sees something different.

DR. GORDON: And this is just the education and training, at this point.

DR. PIZZORNO: Right, just education and training.

Wayne?

DR. JONAS: I have another thing along those line that I think should be changed. Let me find it in the numbered one. Well, this is the reference to internship and residency program. The last sentence there, I think, is appropriate for what naturopaths, chiropractors, and others of the more advanced, emerging professions exist, but I don't think that should be used as a general statement because it is not what they are seeking or what they need, necessarily.