I would suggest we change that to something perhaps like, "In addition, the training of CAM professionals should include post-graduate and continuing education training programs to assure lifelong learning in their discipline."

DR. GORDON: Everybody okay with that?

[No response.]

DR. GORDON: Okay, anything else?

DR. LOW DOG: I'm sorry, Joe, or whoever is running it, on 19 through 23, then, I didn't hear. Did we remove that as well? Have we gotten to that?

DR. FINS: Yes, that is going to go.

DR. PIZZORNO: So I think we should change the language here somehow.

DR. GROFT: Wasn't the language yesterday to include loans rather than loan forgiveness?

DR. GORDON: That is right, Steve. Thank you.

Remember, the decision yesterday was loans, and we would address loan forgiveness when we come to the Final Report.

DR. PIZZORNO: Come to it later, right.

Take out "parity," also.

DR. GORDON: Can we move along now to credentialing and licensure?

DR. TIAN: My question is on page 11, the second line.

DR. PIZZORNO: We are not there yet.

DR. TIAN: Okay.

DR. PIZZORNO: So anything else on education and training?

[No response.]

DR. GORDON: Let's move along.

DR. PIZZORNO: Credentialing and licensure. So we did not come to consensus on specific recommendations on licensure. Obviously, that was a pretty hot topic. I think we all need to take a look at this and see if this is consistent with the more open-ended language that we ended up with yesterday.

I took a quick look and I think it kind of lays out both sides of the issues, but if there is something specific here people want to comment, now is the time.

DR. FINS: Yes, Joe, on age, page 11.

DR. PIZZORNO: What line?

DR. FINS: Well, I am trying to figure that out.

Like in the sixth or seventh, or something like that, this unevenness of oversight. Maybe we want to cast that again more positively and talk about the importance of due process and representation instead of the unevenness, not to antagonize but rather to encourage.

DR. PIZZORNO: It is well stated. It is true, it is well worded.

DR. FINS: Okay, then maybe we want to have a follow up sentence saying something like the Commission heard the need for improved due process and representation in addition. So end on a positive note.

DR. GORDON: Joe?

DR. PIZZORNO: I am having trouble finding it. What line are you on?

COMMISSIONER: Six and seven.

DR. FINS: Or, it could also go down where we are talking about the boards. I mean, this is not a major, major issue here, but the issue of due process was something that people talked about, and representation, on the board, of CAM peers.

We talked about this months and months ago, about the pain management story and having pain and

palliative care specialists on the Federation of State Medical Board and local boards so that when people use dopioids appropriately, they aren't sanctioned, the same kind of model, as an example, that could be incorporated as an example in there.

DR. PIZZORNO: Can you suggest some language to add to this?

DR. FINS: Yes. Right now? My Apple is at home. I would say the Commission encourages increased representation of CAM providers on state medical boards, such as has been the case with the incorporation of pain specialists to improve pain management. It also endorses increased awareness in the need for due process.

DR. GORDON: Right.

DR. PIZZORNO: Excellent. I think that is quite good. Anybody else want to comment?

DR. GORDON: Pay attention to the requirements of due process.

DR. PIZZORNO: Yes. George?

MR. DeVRIES: It is really a question. I understand it is an interim progress report, and I guess the question would be, for the reader who is getting this,

there will be many who don't have a good sense of licensure in CAM, who the providers are, how they vary state by state.

I guess I am asking the question to the Chair and to the staff, would it be appropriate to have a two-page attachment to this, listing out the 50 states and showing, here are the provider types that are licensed or certified in each state: acupuncture is certified in this state; chiropractors are licensed; dieticians are registered.

It would just give a sense of state by state, as well as the variability. I think, for an uneducated reader, they can flip to an attachment, they can go through a list of the states and see what the variability is. Even for the Commissioners, it might be helpful.

DR. GORDON: I think that would be fine. We indicate the variability in the text, and it would be fine to have the attachment.

DR. PIZZORNO: That is an excellent idea.

Anybody else? Any recommendations on this? Ming?

DR. TIAN: Page 11, let me ask a question

regarding line 2 and 3. It says: "Others, such as acupuncture, massage, and naturopathic medicine are licensed only in some states." I think it is more than only. For instance, acupuncture is more than 40 states, and I am not quite sure about massage therapists. We should mention "massage therapists," not "massage." "Massage" is too common a word to use.

DR. PIZZORNO: Maybe we should change that to "are not licensed in all states."

DR. TIAN: That is still negative.

DR. PIZZORNO: Pardon?

DR. TIAN: That is still too negative.

MR. DeVRIES: That should go into the attachment.

DR. TIAN: Actually, most of them are already licensed.

DR. PIZZORNO: Okay, how about "are licensed in many states"?

MR. DeVRIES: That should go into the attachment.

DR. TIAN: Most or many, or all, in some states.

DR. GORDON: If we said many states, but

according to standards that vary from state to state, that would be accurate, okay?

DR. TIAN: Okay.

DR. PIZZORNO: And see the appendix for a list. That would work.

Does that work for you, Ming?

DR. TIAN: Yes.

DR. PIZZORNO: Okay. Anybody else?

Joe.

DR. FINS: Oh page 12, lines 9 to 11 or so, we are talking here about people were saying that only the CAM providers could credential themselves and everything. We also heard testimony from various groups that the entities themselves couldn't agree on the standard for education.

I think here, since Charlotte is saying this is a teaching document, I think we should use the power of the Commission to say that we encourage these organizations to work together and cross disciplinary boundaries and seek to establish professional guidelines that are going to be necessary for eventual consideration for licensure and additional kinds of certification. We

can use the bully pulpit of the Commission to say, we asked those people to have dinner together, and they said they didn't want to.

So I mean, we can put that in press here and try to urge them to collaborate in the spirit of collegiality.

DR. PIZZORNO: You want to say something, Michele?

MS. CHANG: Yes. Going back for a moment to that list, because I think it is relevant as well as illustrative, George and I were just talking, how do we decide, what do we include in that list, because we tried to steer away from talking about specific modalities or looking like we are supportive of -- so what George suggests was that he can provide us with an appendix that is fairly comprehensive. So I just want to raise that.

MR. DeVRIES: I can provide you with lists, state by state, and kind of go into detail, certified versus licensed. You can take that, then, and you can basically edit it down to what you think makes sense to have in the appendix.

DR. PIZZORNO: Great.

So coming back to the point that Joe raised

about encouraging the various groups and subgroups to work together, it makes sense to me. I wonder how the rest of the Commissioners think about that.

DR. JONAS: I would go, I think, even a little further in what you are suggesting, Joe. I think, just like we are saying there ought to be some minimum educational issues that are brought up among all practitioners, licensed, credentialed, or non-licensed, there should be some minimal ethical and professional standards that anybody that is delivering a service should be required to adhere to.

I think that we should put some kind of statement into that effect, such as, basic standards for ethical and professional conduct should be part of all CAM credentialing, licensing in service delivery, or something like this.

DR. FINS: Wayne, if you go to lines 23 on page 12, it is there. There is some of that there already.

DR. JONAS: Yes, I see that down there. I would suggest we make it stronger, and I also think that this is the place to put in some things about deceptive and fraudulent practices, that there should be a process for

the prevention and discipline of fraudulent and deceptive practices and claims as part of delivery and services.

Anyway, I think that should part of whether an individual is licensed, credentialed or not.

DR. FINS: I think, along those lines in that same area, I had identified complications of their intervention, reporting mechanisms, be responsible, AER-kind of participants, we talked about that, infection control, et cetera, et cetera.

DR. GORDON: I wouldn't get into too many details on this stuff.

DR. FINS: No.

DR. PIZZORNO: We just had three new ideas presented to the Commission, actually four, at this point. I don't know how much time we have to go through all of these. I really liked what Wayne had to say about expecting minimal standards, whether they are licensed, credentialed, et cetera, others, or just simply a delivery of service; having minimal standards of education, competency, et cetera.

DR. JONAS: Buford, before you leave, this actually directs --

MR. ROLIN: I know. That's why I waiting.

DR. JONAS: That's why you were leaving.

[Laughter.]

MR. ROLIN: I wanted to hear what you had to say.

DR. JONAS: Well, because I think it should be kept fairly generic, because there are systems that already do that discipline, and we need to be very clear that we don't specify this is how you go about doing it, but that it should be part of it.

MR. ROLIN: Thank you.

DR. GORDON: Let me interject here. We need to come very quickly to a close here. Linnea has also passed me a note, really saying, well, maybe we should wait and shouldn't consider service delivery and access and reimbursement in this meeting.

I think we have to do just the opposite. I think since we haven't considered it, we need, basically, the full hour to consider that. Where we have gone over information development and dissemination at some length, I would like to leave that to do two more minutes here. If there are issues that are left over with information

dissemination, et cetera, that are of concern that are not covered by the discussion, I would like people to get in touch with the staff.

That would be you, Corinne, right?

Because we do need to hear it ourselves and talk with each other about issues related to service delivery and reimbursement.

DR. ORNISH: Could I say one thing? I may have been out of the room when this was discussed, but on page 12, when you get into lines 18 through 27 -- have we already covered that? I really think that you might consider just deleting that, and just leave it at the sentence that ends on line 15: "They will also be addressed in the Final Report," and then delete everything else on down to line 28, because I can't think of many red flags that are going to be bigger.

Even though we are only saying that we are considering two principles, it is going to be very easily read as, this is what it looks like we are going to recommend.

I can just tell you, this is going to be a huge issue for a lot of people, and I am not sure that it is

really worth putting down until we have had a chance to discuss it more fully. I think we are going to get the worst of both worlds here.

DR. GORDON: I thought that these were things on which we had, pretty much, consensus.

DR. ORNISH: Well, because if I were reading this as an Interim Report, and I weren't a member of this Commission, I would read, implicit in this, that basically anybody could be a practitioner as long as they disclose their own limitations, that they don't necessarily have to be licensed.

DR. GORDON: It doesn't say that at all. It just says that all practitioners need the basic education. It doesn't say anybody can be a practitioner.

DR. ORNISH: Well, I think that needs to be made more explicit, then. Maybe it is because of the discussions that we had where people were recommending that anybody could be a practitioner as long as they disclosed to people what their limitations and their credentials were.

DR. FINS: Wayne just said we are seeking to set minimal standards of professional behavior and clinical

abilities. We have sort of had this discussion. So in other words, we are creating a floor here upon which these people would exist.

DR. ORNISH: I know, but I just think it needs to be more explicit, then, if that is the case.

SISTER KERR: There is a point to this, not that I think we aren't going to be speaking of that, but it could make sense to stop with "period, Final Report," because you go on to kind of do a prediction, which we are not doing in other segments.

DR. ORNISH: I think it just raises concerns that are not necessary to go into here, that could potentially be really damaging for our moving forward, until we are ready to address it more fully.

DR. FINS: We had a whole meeting on education, devoted exclusively to education. We had four subgroups. We heard a lot of testimony, we got a lot of background reading and writing. I think, to some extent, I am uncomfortable. We are setting up some standards, some expectations here, which I think is part of the integrated message.

DR. ORNISH: Well, first of all, I mean, all

state licensing boards, anybody who is registered or certified is going to have to disclose their qualifications, education and training, and their license. Is that anything new? I mean, if they are already certified and licensed, why put that in there, and if it something more than that, it could be easily misread. That is all I am trying to say.

DR. FINS: I am more interested in the second recommendation. I think that is the one that is more substantive.

DR. ORNISH: Well, here again --

DR. GORDON: We have got to close. The fact is, Dean, though, that there are people who are practicing without licensure, without certification. What we are saying is, at this point, whoever you are, you have got to say exactly who you are and what you know.

DR. ORNISH: But that is the whole point, Jim, is, people are practicing without licensure and without certification, and implicit in this, it could easily be read that we are saying, that is okay as long as they disclose it.

DR. FINS: [Off mike.]

DR. ORNISH: Then it needs to be just a little more explicit that we are not, because why even put it in there otherwise.

DR. FINS: Another bit here that, just, really needs to be mentioned, that is critical, I think, and it says, "All practitioners should know their limitations in diagnoses and treating."

DR. GORDON: Right.

DR. FINS: I would say their clinical limitations, because diagnosis and treatment may have linkage to a physician licensure, and I don't want to conflate that with other practitioners.

DR. LOW DOG: There are many states in which many of these CAM practitioners are not legally allowed to diagnose and treat. So the language itself is not quite --

DR. FINS: So, if we say clinical limitations?

DR. GORDON: So there are clinical limitations.

DR. PIZZORNO: That is better language.

DR. GORDON: Okay.

SISTER KERR: Is there any reason that we feel strongly to leave it now, since there is a little lack of

clarity, to just clarify Dean's point?

DR. ORNISH: Thank you.

DR. GORDON: I think that we are making a statement with the second statement, that everybody needs to know enough to know what their limitations are. I think it is an important statement.

DR. ORNISH: If they are licensed and certified, it is redundant. If they are not licensed or certified, it implies that we are sanctioning the people who are unlicensed and uncertified, it is okay as long as they know their limitations. Otherwise, why put it in there at all?

DR. GORDON: The reason is because one of the major things that we have heard at many of the testimonies is, this is not true, that people who are licensed and certified do not know their limitations. They think they know far more than they do. They don't refer adequately. We have heard from that conventional practitioners --

DR. ORNISH: Well then, why don't you just put in the words "All licensed and certified practitioners," and then I will be happy?

COMMISSIONER: [Off mike.]

DR. ORNISH: Because you are not limiting it to that. So then, you really are including in that a group of people who aren't licensed or certified, and implicit in that is, for that subgroup of people, you are saying, well, it's okay as long as you know your limitations, and I am uncomfortable with that.

DR. GORDON: But, Dean, there are people who are practicing traditional methods of healing. One of the major issues in other countries that I have worked in is the relationship between traditional healers and conventional, and how they work together, and how the traditional healer knows his limitations, and the conventional healer --

DR. ORNISH: No one would argue against that is always a good idea for everyone to know their limitations. That is not what I am talking about. I am saying that, if you are talking about people who are licensed and certified, of course they need to know their limitations. If they are not licensed or certified, then we are, in a way, sanctioning or saying, we understand there are people out there who aren't --

DR. FINS: These are people who are licensed or

certified who practice outside the scope of their licensure.

DR. ORNISH: Just put that in there. That's all.

DR. FINS: We have heard from some CAM practitioners, who are licensed physicians, that they have never had treatment failures.

DR. GORDON: I think what we need to do is hear from other people, and close this section out.

DR. LOW DOG: My own personal feeling is, if there is this much dissent about it, just put the period up higher and leave it until the Final Report, because I am not sure it is essential in the Interim. I think there are enough people that are having problems with it to just --

DR. PIZZORNO: Jim, I would like to agree with Dean and Tieraona. If there is this much conversation, we are not ready to write this down. Put a period there, and move on.

DR. GORDON: That sounds fine. Let's let it go.

What I would like to do in the interest of sanity, is take a five-minute break, and then come back

and have Linnea lead us through the issues related to service delivery and reimbursement.

[Recess.]

DR. GORDON: We really need focused attention, and Linnea, I recognize a formidable task, since we have not gone over this material before.

Discussion Session VII: Access, Delivery and Reimbursement

Part 1: Access and Delivery

MS. LARSON: The only thing I want to say before we begin this process, this is access and delivery. Following that, we are going to do coverage and reimbursement.

I want to make a comment about the access and delivery. There were 29 sub-recommendations under eight categories. Now, if we had this in a discussion, that would amount to two minutes and 15 seconds per, quote, bullet point. That is for access and delivery.

Under the area of coverage and reimbursement in our briefing book, there were 27 sub-recommendations, and that works out to be about two minutes and 15 seconds, or whatever.

I am putting that in a context for you to

understand how many of the issues that we will not be able to address in one hour under those two areas, which I believe are substantial areas for this Interim Report.

I also want to put another context. Dr. Pizzorno did two areas and had two and one half hours to go over that. Also, with this period of time, we have one hour to look, and I am going to make a suggestion, that we are going to simply go line by line, and if anybody has a substantial objection, addition or deletion, they make it now. If you cannot do it now, then you e-mail your commentary to the respective staff people, Dr. Kaczmarczyk and Maureen Miller, and then we will work on that and get it back within 48 hours.

Is that sufficient?

[No response.]

MS. LARSON: So I say, fasten your seatbelts and get ready to rock and roll.

Substantial changes or deletions in the first --

DR. GORDON: I have a problem with starting off this way. I think it is not a positive way to start off. I think we need to make some positive statements about

access and delivery to begin with, before we move into any of the difficulties.

MR. DeVRIES: [Off mike.]

MS. LARSON: On the first sentence. Yes, I do, too. It is the "barrier." We begin with "barrier" rather than saying, we will embrace.

MR. DeVRIES: You might even want to have an initial paragraph of introduction talking about, on the positive side, in terms of access and delivery, things that are working, and then leave some of the negative comment off for a second paragraph.

MS. LARSON: So we contextualize that. We contextualize that and give it the expansive quality that access can be.

DR. GORDON: Both the expansive quality, and also a little specificity about the kinds of places where people are looking and some of the kinds of programs that have been developed to give people access.

MS. LARSON: That actually was one of my recommendations, is we will cite model programs.

DR. GORDON: Will you do that, Linnea?

MS. LARSON: Yes.

DR. GORDON: Okay, great.

MS. LARSON: To assure the Chair here, I actually have gone through all of this and can pull a lot of it together, but I do want us to quickly move through.

To the other Commissioners who were not here, that I think was very valuable, was that it begins with a negative with the focus on barriers rather than orienting our readers to the positive aspects of access and what has been done already.

DR. PIZZORNO: So it seems like the first sentence should be, "There is strong public interest in having access to CAM practices and products," just in a real positive way. I really liked what you were saying there, Jim.

DR. JONAS: Then you could also say, "There is increasing interest by physicians in the conventional medical community in learning about these areas."

DR. FINS: Again, do we mean here access vis-a-vis entitlement, or just having access to?

Because we have another section which deals with reimbursement, and if we mean having access, I think we have to deal with the issue that is in the second

paragraph of this section about how these things are complicated by the uninsured, the underinsured. Access means something different in the context of health care then it does in access to --

MS. LARSON: This is one of the issues that I thought about, in terms of definitional specificity. Access, to me, actually means adequacy, adequacy of services and adequacy of supply, but that is a technical issue.

DR. FINS: Because the next section is coverage and reimbursement, and I think if we try to sequester the two themes, I think it will be conceptually stronger, and I wonder if there is an alternative way of thinking about access the way you framed it.

You talk about universal access. It is not universal access to quality products, it is an entitlement, and we have talked about that issue and how that complicates things.

MS. LARSON: Dr. Low Dog, because I don't want to do this again to you.

DR. LOW DOG: Thank you, Madam Chairman. Can you just help me. I didn't really pick up on it until Joe

said something, but does it really mean when you say "access to CAM by children is characterized by more numerous and significant barriers than the general population"?

If you just take that out, because it is the whole sentence, like HIV, elderly, but if you just take that one piece and you just read it, "The access to CAM by this population of children" -- "by children, has more numerous and significant barriers." What exactly are you trying to tell me? I am not quite sure what that means. I just need some help.

What are you trying to tell me? If children's access is restricted, elder people's access? Just help me, because Joe raised the issue about entitlement, and part of me is hearing, these populations, there may be more barriers because of economics versus supply, because being a child doesn't necessarily have anything to do with where the supply is.

MS. LARSON: So what you are asking is for clarification in terms. Okay.

DR. GORDON: What I would like to do, which might help, I wrote an alternative three-paragraph version

of this access. I would just like to read it to give people a feeling for a more positive, more contextualized approach, because I think it is a specific issue and it is complicated, each of those is complicated.

This just reads, and we can certainly make copies for people:

> Americans seek out CAM approaches and techniques because they hope that they will improve their chances of overcoming disease, as well as enhancing their long-term health and well-being.
>
> They continue to use these services, partly because they seem to fulfill these needs, partly because those who practice CAM seem more humane and humanly responsive, paren, CAM providers spend significantly more time with their patients than conventional physicians, close paren, and partly because CAM providers engage the patients who come to them as partners in healing and encourage them to learn about and help themselves.
>
> Americans clearly want easy access to safe

and effective CAM services. They want these services to be offered in a way and in a form that can, where appropriate, be easily integrated into conventional medical services.

Though some, particularly CAM providers, have spoken of the importance of maintaining the integrity of various forms of traditional healing, all would agree that they want CAM approaches to be coordinated with, if not integrated into, conventional medical services.

Then the main barriers to this process, which have been presented by the testifiers, include lack of adequate, and adequately organized, information about available research on the appropriateness of CAM products and services for particular health conditions, lack of research demonstrating the efficacy of these services and products for a number of conditions, absence of clinicians who are either trained in CAM modalities or knowledgeable enough to be able to refer to appropriate CAM practitioners, and insufficient numbers in

availability of programs of integrative care.

Overwhelming all of these considerations, especially for those who are uninsured and/or do not have independent means, is a lack of coverage of CAM approaches and practitioners by government programs and HMOs, and by insurance companies."

That is just trying to give it a broader context. I will give that to you, Charlotte, to work with, if you would like.

MS. LARSON: I am sure Charlotte will be very helpful on this process. I really appreciate that.

I guess I am a little bit confused because of our process issues right now, and that is, going through what is actually written, and then if there are substantial deletions or additions, expansions, or basically saying, look, I don't understand this; this needs further clarification. Also, I put a time frame on it. We don't have much time.

DR. FINS: Let me just say one thing. Jim's comments really helped me with Section E and Section F. Just imagine, Section E is for somebody who has got money,

who has got insurance, and it is problems with the system. It is the integration of the system, multiple modalities, the complications of therapy, different providers. It is sort of the systems of care and the disorganization issue.

Section F addresses, okay, the system such as it is, how do we deal with coverage and reimbursement, and the economic barriers of access. Section E, I think what is probably meant to be here is to say that a cancer patient has got numerous and significant, but more significant barriers than the general population. It is not because of a financial issue, it is just the comorbidities that that individual may carry.

So this is almost health services versus the individual's ability to pay. I think that might be what is implicitly there, but I may be wrong on that.

DR. GORDON: Linnea, can I explain for one second why I read that? The reason that I read it is because I feel like what we have here is so focused on the barriers, and that it is hard to do it line by line if we are shifting the approach to a more positive approach, that somehow the barriers have to be integrated into the whole discussion of access rather than focusing on the

barriers to begin with. That was what I was trying to convey.

MR. DeVRIES: If you look at the issue of access, you look at it as a regulator would look at it, from a health plan perspective, they are going to define access as -- for example, let's take acupuncture. In some states, a member can self-refer, go to directly to an acupuncturist. In other states, regulation is going to say that there has to be a diagnosis or a referral from a physician. So that is the access. The reality is, in CAM, is most states there is easy access. That is a positive.

The other point of access that they are going to look at from a regulatory standpoint, which I think can be positive, but is very telling when you see the numbers, is, the numbers of licensed, certified, registered practitioners, providers of CAM, state by state. I have that information.

When we give you the exhibits related to licensure, not only can we show, here is the requirement, state by state, of provider types and who is licensed, certified or registered, but here are the number of

available providers in each state.

There are some telling signs. There are some states where, even though there is a license statute for acupuncture, there are 30 acupuncturists licensed in the state. Well, that is not good access. There are other states where you will have thousands of acupuncturists that are licensed and operating in the state.

So I am just talking from another perspective of access, which is really measured in terms of availability. This is the point where you can say, there are a quarter of a million CAM providers who are licensed, certified or registered alone, to say nothing of everybody else.

MS. LARSON: So we have two things on the table. One was expanding our understanding of access and how we address this as focusing on the positive. The other is a critical issue of defining, or expanding what is access in terms of understanding a regulatory perspective.

And mine was, looking at what is the definition of access that we do understand, which is, do we have adequate supply, and what constitutes an adequate supply.

I'm sorry, go ahead.

DR. JONAS: So, are we talking about

availability, then? I mean, should the whole Section E be changed to something like availability and delivery of appropriate CAM practices?

MR. DeVRIES: Maybe we should split this into sections, because the availability of CAM practices and products versus the delivery are two wholly different topics. They get confusing when you start overlapping them.

DR. JONAS: But I don't know if what we are interested in is two different topics, because what we are interested in is simply not having lots and lots of practitioners available. What we are interested in is delivery of quality services.

So it really is about providing quality services, as defined however. In that sense, then, you could get rid of "availability" or "access," and just say "appropriate delivery," or "the delivery of appropriate CAM services," or "the delivery of quality CAM practices and products," something like this.

MR. DeVRIES: Wasn't "access" one of the terms in our charter that we were trying to build?

MS. LARSON: It is the fourth. It is access and

delivery.

DR. LOW DOG: It comes back to me again, if we could just be a little specific here, because I will tell you what people will read into this. They will say, so we want to have Yoga teacher every 3,000 or 2,000 people or something.

Do you know what I am saying? It is like, what are you actually advocating that there is access and availability to, and how would you go about correcting that? I am not hearing any specificity. You know, are we going to have a Feldenkrais practitioner in every town of more than 5,000 people?

See, you laugh, but what I am saying is you can read any of that into this because it is not very specific.

DR. GORDON: How would you make it more specific?

DR. LOW DOG: I am confused when I read this because it talks about the barriers to access. I have problems with it because then we are talking about availability, and I am not sure of what we are talking, to whom of what.

So I can't give you a lot of feedback, only to tell you that Section E, to me, is just confusing.

DR. CHOW: Jim, there were some good thoughts in what you presented, but it was too much and too fast. I would like to have a copy. I think we should all have a copy now to look at it.

There is only a couple of things in what you said, but just immediately hits me, is "more humane." I think immediately cut that out and say "more humane." The other is integration into the medical services. Those are two kind of red light things.

But I really would like that. I think that would set the parameters, the positive aspects, and I go along with the positive thing. Okay, that is it for now.

DR. FINS: I think this section is really a pivotal section, and there is something really huge that has to happen right here. We have to somehow say, look, the way the world is designed right now, there are these two competing spheres, and whatever principle we have here, we have to have an integrative approach that builds up to whatever is probably behind Number 10.

But the point here is that there are

difficulties to providing good conventional cardiac care. You need ambulances, you need emergency rooms, you need labs, you need cabbages, you need diet, you need prevention, you need all these things.

Putting all those pieces together had a set of challenges. There are challenges that are unique to CAM, the provision of CAM, but there are additional meta challenges in integrating that CAM world into the conventional world, and vice versa. I think that is what we are talking about. We are talking about a delivery system that accommodates the entire panoply of services in a responsible and safe way.

Then you also talk about having economic access to that system that has been developed, and I think that is what is not here right now. It is really a health service delivery system that is truly integrative, and the challenges that are there in bringing that to bear.

DR. GORDON: One footnote. I would agree with you, Joe.

One footnote to that is, how much do we have to ask, Linnea. How much do we want to include in this particular place. As you pointed out, there are 29 or 27

separate issues, and my feeling is we have to make some kind of general statement about what there is, what we are looking for, and what the barriers are, and not get into it much more deeply than that, and then really grapple with it when it comes time for the Final Report, because I just think it is so complicated. That is my thought at this point.

MS. LARSON: I guess I concur. I agree. However, this is the opportunity for people to be able, right now, or in the next 24 hours to send by e-mail, their specific things, having looked at some of the recommendations that were made.

So if we can agree on an overall kind of conceptual or organizing principles based on those.

Wayne, you look ready.

DR. JONAS: It seems to me that if there is one of these principles that we delineated that this section is addressing, it is Number 3 here. It is about freedom of choice and the ability to access or to have available and to choose, if one wants, a particular types of practices. That is the principle that is based on.

It seems to me that that is what we are talking

about here. So if that could be the focus of this, I think we might be getting at what this is about.

DR. BRESLER: But it is also about Number 1, which says that, "The Commission is for the improved health of Americans by ensuring the availability of safe and efficacious services and practices."

COMMISSIONER: I think they were talking about availability.

DR. GORDON: It is also about Number 5, because that is the kind of health care that we are looking for.

MS. LARSON: I would like to make a subcommentary here. In going through all of those 29, those were actually taken from all the testimony, those bullet points in access and delivery. These were the concerns that we heard in testimony that were grouped under those eight categories.

So I want us to be mindful of that. When I was going through, reading through them, and just saying, these are the areas that we have to pay attention to.

SISTER KERR: I am just going to comment, partly on your strengths historically, professionally, but again, I am going to apply my litmus test of teaching tool and to

see, pulling out the basic concepts. When I spoke to your professions background, I think of you as teacher and working with people who could understand what you were teaching them. You had to work with many educational levels.

My point is, can you apply that to this so that the major concepts can be read as a story, even, to just play -- this is more an editorial comment again -- so that, we can say, what is the story about who we are right now, and what is it that we desire to achieve; what is the desired outcome?

MS. LARSON: Are you asking me that individually in terms of capacity, or are you asking me as that is what I think an overall design or pattern ought to be in terms of discussion of access and delivery?

SISTER KERR: I think part of what we are dealing with is presentation here, that it is a complex subject. We identify the principles, but then when we get to the content, it is a hard story to tell. It is a story that the people requested of us, but now we are trying to present it, and how can we present it in a way that is understood.

That was why I was just, maybe not so clearly saying, I thought that was one of your strengths.

DR. GORDON: I think one of the --

MS. LARSON: I do want to answer this. I do think that, actually, every section has a story and a narrative, and a particular type of language that fits the section. So I think that that is just for every section.

I also want to go back to why certain of these things were put in here. It is because these were taken from the commentary that we got in testimony, and bulk of it focused on, quote, barriers. So I think we need to listen to that, but we also, as Wayne and Jim and Joe said, contextualize that by offering up, yes, we have heard this, but there are other things going on, too.

So that is part of being able to develop a narrative. I hear it.

DR. GORDON: I think the story is that there are certain kinds of services that people have a sense that they want, that a number of people, individuals and groups have been doing their best to provide.

That is the aspiration, that is the story, that is what drawing people on. Then there are the various

barriers that come in between most of us, and especially certain people, in finding those services. Then there is whatever light we can shed on that, based on what we have heard and based on our discussions, to see how we can begin to address those barriers.

I think that the difficulty we get into is that if we are going to address the barriers in tremendous detail, we can't do that here. I think that the responsibility and the really difficult task, once we have told the story, is figuring out how to make a new ending for it.

MS. LARSON: I do want to throw this back to the other Commissioners to again refocus and to say, does anybody have any other substantial issues that they want to bring up? We also agreed that there is a narrative problem here, and a structural problem.

I also want to ask for the assistance here of the people who were really involved. I think Dr. Kaczmarczyk did a great job of pulling out from very difficult testimony the actual stated, quote, problems. These were the problems that people felt.

Do you have any commentary on that, Doctor?

DR. KACZMARCZYK: The testimony focused on barriers, and that is why this section began with barriers. It was reflective of the voice of the people.

MS. LARSON: I really want that reiterated. We are just looking at what was said, and we as Commissioners shape this, and we say, yes, we heard the barriers; we also have other issues, too.

DR. LOW DOG: But this doesn't really tell me what the barriers are. There are more barriers in certain groups. I mean, I think we could do a better job with this. If we were really honest, we would say the major barrier for many people is money. I mean, it is the underlying thing that keeps a lot of people from being able to afford to do many of these things, is money.

It just isn't clear in here to me. It doesn't spell out to me what were we told are the specific barriers.

MS. LARSON: I would actually like to make a comment. I don't know if the major barrier is money, in terms of what we have looked at as expenditures on what is called CAM, that would be restricted in terms of a population that is restricted by lack of money. So I

think that is one consideration.

DR. LOW DOG: I think it is considerable. I think it is a considerable one.

DR. GORDON: In the interest of time, because we don't have much time, Tieraona, do you want, and Linnea, do you also want Joe, or some combination of people, would it be helpful, in addition to the overview and the direction that people are trying to go in, to spell out more specifically some of the barriers that were condensed here? Would you find that a helpful process?

MS. LARSON: I have gone through everything and rewritten every single one. I would really appreciate -- I will gladly xerox and e-mail to everyone, because this was supposed to be a systematic process of bit by bit, going through and rephrasing and getting some kind of agreement.

Right now, we are exploring a territory. That is what we are doing here. We are not specifying.

DR. GORDON: I just want to remind everybody, and in a sense apologize collectively, the reason it happened is because we decided we wanted to work on basic principles. We are just sort of working, and

unfortunately, the extended discussion got squeezed out. So we are trying to make up.

If you can provide us with that, that will be a major move forward, and then if you would like feedback about the presentation -- how would you like to proceed, then, Linnea?

MS. LARSON: Well, I actually presented something for a consensus, and that is that any objections, deletions, expansions that anyone has to the areas of access and delivery, if they could, by the time they get home or within the next 24 hours, offer them up to both Joe and to Maureen.

DR. LOW DOG: Maybe we could make it the day after Independence Day, make the recommendations?

MS. LARSON: Oh, I forgot all about Independence Day.

DR. GORDON: Linnea, I think we responded, to some degree, to what is here. I think we need to respond to some of the additions that you have, and some of the clarifications.

I don't mean here. In a sense, we have created for some homework for ourselves. We haven't had the time

to cover it in depth, so the way we will get input into the development beyond what we have here is to respond to the work that Linnea has done on this section, and then the staff can put together the various comments together with what she has done and our comments on what is here, and then reshape this section.

Does that a fair enough as a way to proceed, given the exigencies of the situation? Linnea, is that okay with you?

MS. LARSON: I am considering it. I want to hear from the --

DR. FINS: I just want to go back, since we argued, for just a few more moments. I just want to ask the group whether or not it is helpful to conceptually distinguish access or delivery systems for groups, and the infrastructural problems about CAM delivery, is really what we want to talk about in E.

In other words, even if you had all the money in the world right now, where is that thing that Bill was distributing before. Bill Fair, if he were here, would show us his brochure. This is an integrated delivery system. That is a kind of model.

I mean, the one thing that those of us that went out to Seattle were so impressed with was how they had a clinic, they had a university, they had relationships with the University of Washington, the medical school, they were doing basic science work, they were doing outcomes research. It was the package deal. The whole county was kind of a package deal. So that is a delivery system.

So if you are in Seattle and you had money, and even if you didn't have money, because they did pro bono work, you would have access. If you got sick, you would get referred out, or if you needed wellness, you get referred in. It was coordinated and integrative, but right here, I am sure that would happen, or some other jurisdiction. So I think this is an example of where we want to take demonstration projects, develop systems of care.

Community health centers could have a major role in that. I mean, there are all kinds of things the could happen in this context, but that is at a higher level than the decisions of individual patients or their families. So I think we should say E is systems of care, and F is individuals accessing those systems.

DR. LOW DOG: Yes. I like the separation of E and F, because I think what you just said is much stronger for E than what we have got.

MS. LARSON: I actually, in part of my writing, through some of this and in conjunction with Joe, I said, if we are doing something that is, to date, what we have heard and we are looking at delivery, let us review the models of delivery that we have seen and witnessed in this report. We have access, and then we have, let's review the delivery.

So we have a continuum here. Those models provide a different reimbursement and different coverage. I mean, we are on access and delivery, but these issues of coverage and reimbursement really do overlap.

DR. GORDON: So, Linnea, can we move on?

MS. LARSON: To coverage and reimbursement?

DR. GORDON: I personally like the idea very much of presenting some of those models. I think that would be very helpful to everyone reading the report.

MS. LARSON: That is a way of focusing.

DR. GORDON: Pretty soon, quite soon, we need to move on.

Incidentally, for the public comment, we apologize. We will be going a bit late, and probably public comment will not be beginning, anyway, until a quarter of four.

Go ahead.

DR. JONAS: I just want to make one suggestion. I like the trend, what you are talking about here. I think that by describing some of the models we have seen where there are access and good delivery would be a useful way to begin it with a positive trend because it shows, what people really want, and there are some places where they are actually getting it, but then focus on the barriers because those are the major issues.

I would just add one other thing under barriers, which you probably already have in there in terms of resistance and lack of availability. Many physician really don't have an understanding of these.

MS. LARSON: That was one of my points, Wayne.

DR. JONAS: That word wasn't in here, and that is, to me, the major one. They just don't know what these areas involve. They don't know anything about the herbs. And so, the patients say, why should I ask them. So that

just should be part of it.

MS. LARSON: That was part of the line-by-line deconstruction.

Discussion Session VII: Access, Delivery and Reimbursement

Part 2: Reimbursement

MS. LARSON: So we have a few minutes on coverage and reimbursement. We have six areas now, reduced to 27, a lot of work that Maureen did to put this together. I also want to commend Joe for that agonizing job, of pulling out all of that testimony and putting it into order.

I want to, very quickly, make a distinction. I want us to have a discussion on this, about the difference between the concept of coverage from reimbursement. Coverage, I believe, is a policy issue. We ask, is someone covered or aren't they; is it affordable, or is it not.

Reimbursement has to do with rate of pay for a service. There are organizations and agencies in the federal government that are involved in that. These are policy questions related to coverage.

Does anybody else have some commentary? Thank

you. Maureen.

MS. MILLER: I just want to clarify that when you work in the area of health care payment or reimbursement, you actually have three areas of policy, eligibility, which we are really not dealing with here, coverage, and reimbursement, because it is not just a rate of payment. There are different ways to pay for anything, prospective payment, DRGs, capitation, fee for service, discounted fee for service.

So there are policy decisions on how you are going to pay, and even how the model is constructed, what goes into the factors, like a DRG. People fight for years over what the elements are in there.

So I just wanted to make that clarification.

DR. FINS: I mean, I personally thought this was a really tight section.

MS. LARSON: You had some comments that you wanted to make.

MR. DeVRIES: Yes. I, too, like Joe said, I think this was very well done related to coverage. I think it realistically portrays the issues that are out there that we face, how the decisions are made and what it

is going to take to make real changes related to coverage issues.

Really, the only suggestion I would have is, I think we could insert a few sentences on the front end in the initial paragraph, because maybe we could say something about what is happening. We could say there are currently benefit programs, affinity discount programs, as we heard during testimony, that covers everything by health plans across the country, from chiropractic, acupuncture, massage, naturopathy, nutritional counseling, guided imagery, yoga, herbal supplements, vitamins.

So there is really a lot going on out there, but it is not the majority of the population by any means. It is happening, to some extent, with both private payers, employers, as well as government payers. Government payers have got into some a little bit.

So maybe a few sentences on the front end. Then finishing that first paragraph, we could acknowledge, however most Americans do not have access to coverage, and then in the next paragraph you begin saying, the lack of insurance coverage. That kind of leads right into where some of the challenges still are.

DR. GORDON: That makes sense to me, George. The thing I wonder is whether it wouldn't also be good to have a couple of instances where the programs seem to have worked effectively. That is, either where the insurance companies have done very well by doing good, or where those programs have demonstrated certain kinds of benefits for subscribers, some evidence to frame it.

MR. DeVRIES: Absolutely. I agree with you, Jim.

There are a couple of examples we could make. One example I think we ought to point to is the State of Washington, related to their coverage for all the CAM provider groups. Also, now there is some data out related to not cost offset, but total cost in showing that it was less than projected in member satisfaction. There are some positives there.

Then, outside of the State of Washington, in places that are more of a private sector, free market system where coverage is optional, there are a couple dozen good examples across the country, everything from BlueCross\BlueShield Association to up in New England to the Southwest, all over the country. So it is just a

matter of picking what we want to focus on. Those are good examples.

MS. LARSON: Are you suggesting that we put that in two places, in access and delivery, and in coverage and reimbursement?

MR. DeVRIES: That is kind of your and the staff's call. It is up to you. I mean, there are a lot of good examples of good things that are happening out there and progress that is being made. I think it would be good to point to some of those things as really good examples of what can be done.

MS. LARSON: Can you get that information to Maureen?

MR. DeVRIES: Sure. If you can give me a little direction on what you would like to see, what you think I described that sounds on the right track, and what doesn't, because there are a lot of choices. It is just a matter of what you want to --

DR. GORDON: I think the Washington State example.

MS. LARSON: I would like to just open this up for everybody.

DR. GORDON: I'm sorry.

MS. LARSON: I think I would like to open it up for everybody to make a comment on what he is offering and his suggestion for illustrating. I think Joe had his hand up here, or his elbow in my side.

DR. FINS: On page 18, we have all those bullets there, all of which I agree with. This is something that I feel deeply about, and that is the issue of universal access. I appreciate George's earlier comments about not opening that Pandora's box, but I would very much like a bullet that somehow captures, and we have to finesse it, that we are not looking to this as an alternative for coverage, for conventional coverage, that it is not as an alternative to it, because we are not talking about coverage, we are talking about people who don't have access to insurance for CAM.

Do you have a solution, a language? Because, as I said before, I thought it was ethically untenable to have a CAM benefit when we don't have a prescription drug benefit. I don't want to open that up. We don't have a prescription drug benefit either.

MR. DeVRIES: I think on that particular issue,

for example, from a regulatory standpoint, my experience has been you can't provide the CAM benefit unless you have a basic medical benefit. It doesn't mean you don't have uninsured, it means that your issue of somebody accidentally buying a CAM benefit because they think it somehow gives them a major medical benefit, from my experience, is being handled on a regulatory level.

There could be a statement, something which would say, the addition of CAM benefits should be made over and above the basic medical benefits.

However, to make a statement saying pharmacy comes first, then comes mental health, then comes CAM, I don't think you can go there because, again, especially in the private sector system, they are making their own decisions in terms of how they fund coverage, and they may choose not to cover pharmacy and cover mental health and CAM, or vice versa.

DR. FINS: I think, then, if we said something in the context of those who have preexisting health care insurance, these are the criteria.

MR. DeVRIES: In terms of the way the private sector insurance system works, I mean, to basically put a

prerequisite in saying for new plans that decide to offer coverage for CAM or employers, they have to offer these other benefits too, I don't think we want to be prescriptive.

MS. LARSON: Effie and Tieraona.

DR. CHOW: I think what George is saying is really good, demonstrating that there are some things happening. I would caution to use the term that a lot of things are happening. I think limited amount of activity is happening, when you look at the large scale. Also, the kind of reimbursement that is given, the amount of reimbursement, I think, is still extremely limited.

So I agree with that positive statement, but not to over --

MS. LARSON: Exaggerate.

DR. CHOW: Okay, yes.

MS. LARSON: Tieraona.

DR. GORDON: Linnea, I just want to clarify. If, as Effie is perhaps suggesting, even as we are talking about the positive, we talk about the limitations as well within the positive.

DR. CHOW: Not to let the people think that

there is lots going on, and why are we concerned so much about this other issue.

DR. LOW DOG: Yes. We should point out that it is coming and that is happening, but it is not overwhelming.

I think, Joe, this is one of those land mines for, especially, conventional practitioners, but I don't with private insurance, it is really the place, because I think private insurers can pretty much set what they want. I am not opposed, if you didn't want medical coverage, if you just said, I just want a CAM insurance, and somebody offered that, just offered a coverage like some states are offering CAM packages.

I don't think you can regulate that. I don't think we even want to have an opinion about that. I think when it gets into Medicaid, Medicare, other types of programs, I think then the government, which we are all paying for, I think that comes to a different issue. But I think with private insurance, I wouldn't go there.

DR. FINS: I don't want to in any way foster a situation where people are getting CAM modalities because it is cheaper and it is more accessible, because they

can't afford conventional health care.

We have heard testimony about that. We heard that from Dr. Huerta, about the Hispanic patients who seek the CAM modalities because they don't have access. That, to me, is something I don't want to in any way encourage or foster, to use those words on the negative side.

So I think we need to have a backstop. I agree for the private, I agree with George about what he said, but I think we need to be very clear that if Medicaid or Medicare, or any other federal entitlement program is going to have this, then it has got to be in the context of prior insurability and prior access to insurance.

MS. LARSON: Maureen, a clarification, please?

MS. MILLER: Well, I was thinking, it may not totally capture your concern, Joe, but back on page 17, when we are introducing the bullets, on line 25, I don't know if we said something about, in general, they -- we are referring to the people who testified -- were open to considering expanding benefits to CAM if these next bullets were met, expanding or extending.

MR. DeVRIES: Expanding current coverage to include CAM?

MS. MILLER: Current benefit packages.

MS. LARSON: Are you on line 25, Maureen? Twenty-five, page 17?

MS. MILLER: Ah-huh.

MS. LARSON: Okay.

MR. DeVRIES: Could we say, in general, they expressed openness to considering the expansion of existing benefits plans to also include CAM services, provided they demonstrated? Does that work, Joe?

MS. SCOTT: I guess I am feeling very uncomfortable with the amount of time that we have to deal what I think is one of the most important parts of our report. Certainly, access and reimbursement and coverage are critical issues. We have heard from every community, certainly the community I am most familiar with, the African American community, and I feel that we are giving it short shrift.

I know Jim reminded us when we decided to do the principles that we were going to be giving up some time, but I am feeling very uncomfortable with trying to sort of force in this time -- I feel it is important that it be acknowledged and something be said in the report on this,

but I don't want to feel pushed to come up with recommendation that we don't really feel comfortable with, and that we haven't been very thoughtful about.

MS. LARSON: I feel very strongly with you. I mean, this is such an important topic, and we haven't even addressed, under the area of coverage and reimbursement, the 42 million people that are under- or uninsured.

MS. SCOTT: Right.

MS. LARSON: This is huge.

MS. SCOTT: My other angst is that the public is waiting for their comment. They have been here throughout the two days, and it is a holiday for them, also, and it is getting later and later. I don't quite know what to do about it, but I just felt like I needed to say how uncomfortable I am feeling.

MS. LARSON: Tieraona.

DR. LOW DOG: Well, isn't it possible that we don't have to make lots of recommendations or whatever? Can't we just say in throughout Interim Report that this is an area that is very important to the Commission and that we are seriously exploring, and our recommendations will be in the Final Report? Can we just sort of keep it

minimal, and then really come back to give it the attention it needs in October?

DR. GORDON: I think that we can do that, and we can make the kinds of statements that we made here and that there seems to be a consensus about. Then in October, we can move into this first, this topic first, and devote the time that we need to it.

MS. LARSON: So we can agree that we will change some wording around in access and delivery to illustrate, through models of delivery, that we have changed the first paragraph into a little bit more positive, et cetera. Then add the barriers, et cetera, and then say, in our Final Report, we will be addressing these other issues.

But I really do want it in our next meeting that we are going to be covering, line by line, some of these.

DR. JONAS: Yes, I agree with that. I think there are so many things that we haven't even touched on in here, that we heard about them, even things like practitioners who say, to heck with this system; we are just going to be sucked onto a sinking ship, and this type of thing. I mean, we haven't even touched on those.

I also say that even though there may be some

examples of successful coverage and benefits, that is the minority or we have very little, and the vast majority, is we know nothing about it, or most of them have been failing. That hasn't been addressed. So I wouldn't put too much of a positive spin on this particular section.

DR. GORDON: Most of the interventions have been failing. Is that what you mean?

DR. JONAS: Most of the systems that have attempted to go into the standard health care system, delivery CAM services, get reimbursed, and be economically successful, and provide those services, are not working.

MR. DeVRIES: Well, you are talking about integrated CAM clinics. You are not talking about benefits. This is a whole different issue.

DR. JONAS: Okay. So maybe that is over in the delivery section.

MR. DeVRIES: Because the integrated clinics, from a fiscal standpoint, aren't working, but in terms of the benefits in the State of Washington for CAM, it is hard to find anybody up in Washington who would say it has been a failure.

DR. JONAS: It hasn't been there long enough.

DR. GORDON: Wayne, let me make a suggestion. This is one of those complex areas that we really need to address in more detail. I think that the general kind of approach that we are talking about is really as far as we can go, at this point, with access and delivery.

MS. LARSON: Maureen?

MS. MILLER: There was one minor thing. I am comfortable with dropping the recommendation, but I am wondering if we could keep some language in on the demonstrations, only because, again, this whole fiscal year. If we wait until October and don't mention anything at all, then we have lost a whole year where Congress could act on that.

MR. DeVRIES: Aren't we leaving the coverage section as is, other than the addition of a paragraph? We are leaving it as is.

MS. MILLER: Oh, I thought there were conversations about not --

DR. GORDON: That is access and delivery.

MR. DeVRIES: Yes. The coverage section stays as is, except for a paragraph on the front end, and there was that one sentence to meet Joe's concern. That will be

changed, but otherwise, it is a good section for coverage.

DR. GORDON: Okay.

MS. LARSON: I want one more statement before we go on. I'm sorry. I really do want some more information about the community health centers, because I think that they provide an excellent model for collaboration, and they are an excellent model to really examine for uninsured and underinsured.

DR. GORDON: Linnea, I just want to clarify. You want more information, so that we can read about it and discuss it in depth for October.

MS. LARSON: Yes.

DR. GORDON: So, Joe, will you be able to help us with that? That would be great.

DR. FINS: I just wanted to answer that. I think that that may be a way of having demonstration projects to foster and extend the work that is already going on in those centers, and then grafting it to a preexisting program.

DR. GORDON: Okay. Thank you very much.

I wanted to say a couple words, first of all, to thank the staff for crafting all of this work for us. It

has really been invaluable and made it possible for us to be here.

[Applause.]

DR. GORDON: The other thing I want to say, too, although I said it earlier to the audience, as Michele pointed out, there are a number of people who have come in since early this afternoon, on the wall and what we have been talking about are not the recommendations for the Interim Report. We are still very much in the process of working on and crafting the Interim Report.

Again, to go over what I said earlier, the Interim Report is going to be presented to Secretary Thompson on July 16th. After that, it will go through a process of clearance, and then Secretary Thompson will present it to the President and Congress. At that point, the Interim Report becomes final and public. Thank you.

We are now going to begin the session of public comment. I know a number of Commissioners have to go, and I am glad that those of you who are staying are here. So thank you for that.

We are sorry that we have taken some extra time. We apologize for those of you who were here to give us

public comment, and we appreciate your indulgence and patience. We will begin with Scott Bass.

Public Comment Session

MR. BASS: Thank you, Mr. Chairman. Given the situation with time, I will get right to the point. I have left with the Chairman of this Commission a copy of my second book on dietary supplement law. I hope you have it there. It addresses many of the issues that I understand were raised at prior sessions.

I am head of the food and drug group at a large international law firm, Sidley Austin, and an adjunct professor at Georgetown, and I wrote a large part of the dietary supplement law, and I have written two books on it, and I have testified as an expert before Congress on the issue. So I am happy, in the future, to provide input to this Commission, if they desire it.

I just wanted to address two main points. The first is, there are seven powers -- eight powers, actually, but seven powers that FDA has to regulate dietary supplements, six of which are new and provided by the 1994 law.

The stories that you read, and I have heard

repeated, that dietary supplements are unregulated, are unfortunate. They come from a publicity campaign that FDA began in 1994. Then in 1999, the new commissioner of FDA, Dr. Jane Haney, said, that was untrue; we do have enough powers.

I also represent pharmaceutical companies and major food companies, so I am fairly balanced in my view on the bona fides of the dietary supplements industry, but having been involved with law, working with FDA, as I do now, on some projects, on one project, rather, and I have heard that this Commission had statements made to it or by it that were inaccurate about the regulation of dietary supplements.

In my testimony you have, I have spelled out six of those new powers that protect the public. The problem, very simply, is that FDA chose not enforce the law in order to get the publicity value of saying there was not law to enforce. That has changed. Now it is just a question of more funding by Congress, and better industry self-regulation.

Industry has done a bad job of regulating itself. It needs to do a better job. Congress needs to

give more money to FDA to more enforcement. But the enforcement power is there in the law.

The second point, and last point is, as somebody who deals a lot with legislative issues affecting health care, and I also do health care fraud and abuse work, I think it is very important that this Commission look at approaching this whole issue of CAM from the perspective of changing the definitions of drug and food, and the food and drug law, and changing the reimbursement laws under Medicare and Medicaid, and influencing the states, perhaps, to look at their laws.

Without going into any detail, because of the time, I just would respectfully submit that the issue revolves around changing the statutory scheme and getting Congress to allocate funds proportionally. Thank you.

DR. GORDON: Thank you very much. I am sure that we will come back and be asking you for some of those more specific recommendations in the question period.

The next speaker is Dannion Brinkley. Welcome.

MR. BASS: I must leave. I'm sorry.

MR. BRINKLEY: Hi, everybody. Thank you very, very much. I know most of you --

DR. GORDON: You have to leave now?

MR. BRINKLEY: Both of us.

DR. GORDON: Both of you?

MR. SCOTT: Yes. I'm sorry, I have an airplane to catch. I unfortunately thought it was 3:00.

DR. GORDON: Do you have a few moments?

MR. SCOTT: I have like two or three minutes, yes.

DR. GORDON: Dannion, excuse me, can we just ask a question or two?

MR. BRINKLEY: I am on the same flight with him.

DR. GORDON: You are on the same flight? Okay.

COMMISSIONER: Let's hear both of them.

DR. GORDON: We will hear both of you, then, and we will ask both of you questions. That will be fine.

MR. BRINKLEY: Well, mine is very simple. I know most of you, and most of you know me. I have been a part of this now for 16 years. My issue is dealing with taking a very specific area and getting and making a recommendation, as you put forth this to the President of the United States and Congress, that we should take the simplest forms, the things that are simple, the

therapeutic touch, the whole concepts of energy medicines that can be applied, and to apply them.

I have been a hospice volunteer for 24 years, and I have over 8,500 hours at the bedside of people leaving this world. In the advent, since 1996, of palliative care and hospice care, I have seen some remarkable things happen with simple practitioners without any licenses in care, concern, and compassion.

I believe that the fact that we are in a position where 45,583 veterans leave this world every month, and over 574,000 leave this world every year. The palliative and end-of-life care programs that complementary therapeutics can be used to help gives us a way to back engineer medicine.

I believe what is really important to us is the quality of end-of-life in what is now an encapsulated group called the Veterans Administration, and that we take these programs and we bring them forth. I have watched aromatherapy, music therapy, therapeutic touch, and what is now called frontier medicine, as energy medicines being actively used and successfully in men and women who have served this county very, very well.

I am very thankful for the input that I have watched each of you put in so that nothing happens to harm what we are trying to move forward. I am a recipient of complementary medicine. I believe that conventional medicine saved my life, and it is complementary medicine that keeps me alive. I see this as a way to take medicine at the end of life, and back-engineer it to the beginning of life, because they truly work. You make me all very proud of you. Thank you.

DR. GORDON: Thank you very much, Dannion.

MR. BRINKLEY: I would like to show one item. This is as advanced therapeutic alternative therapy as I use. I don't want this to be regulated. It is amazing what a veteran can do with one of these in scratching or rolling or a muscle cramp. So as you write and restrict, please don't allow such advanced therapeutics, complementary and alternative, to be licensed and regulated. Thank you.

DR. GORDON: Thank you. Questions for Scott Bass and Dannion Brinkley. They have time before they have to make the plane, a couple of questions.

Go ahead, Wayne.

DR. JONAS: Mr. Bass, would you agree, then, that if DSHEA was fully implemented, that a lot of the issues that are being discussed would be resolved, or at least addressed?

MR. SCOTT: Yes, completely. It is a matter of funding, and also, bad tactics that prevented it.

DR. GORDON: Do you want to say a little bit more about what you mean by "bad tactics"?

MR. SCOTT: I don't really have time to go into the whole story, but basically, in 1996, when the ephedra controversy hit, FDA had been very upset about DSHEA for obvious reasons. They could have killed DSHEA as a product with one lawsuit under a new power that DSHEA gave them, but instead, the Commissioner then chose to say --

DR. GORDON: Killed ephedra as a product.

MR. SCOTT: That lawsuit won in about a day, and I say that as a legal expert. Instead, they chose a campaign for three and a half years until the Commissioner left, and the main person who had negotiated DSHEA, Congressman Waxman, who was then in FDA, said, "We have no powers and we can't do anything; that's why we are not

doing anything. In 1999, when Commissioner Haney came in, she said, "That is not true; It has never been true; We just need to enforce better.

DR. GORDON: Charlotte.

SISTER KERR: Either of you, but in particular, Dannion, is there any particular principle you think we left out of our principles this morning that is important to put in?

MR. BRINKLEY: There is a spiritual nature about all of us. What brings people to become doctors or healers or practitioners is a spiritual connectiveness that we all have. Without putting that into it, no matter whether it is governmental or separation of church and state -- I am a faith-based organization because I believe in American service. I believe in the American military, I believe in this country, and I believe in the diligence that you people put forth in trying to find exactly what will help and heal people, and keep us in harmony with each other.

There is a spiritual principle about the value of who we are as humankind, and I think it should be put in there. Healing is not just chemistry, healing is a

part of wellness that we alternative all have when we see someone who knows how to take care of us, walk in the room and we know we feel safe. That is a principle that must be guarded and preserved. Thank you.

MR. SCOTT: Mr. Chairman, I am afraid I am about within one minute of missing the plane, so I have to apologize to you all.

DR. GORDON: Okay. Thank you very much for coming, and we look forward to being in touch with you in the future.

Thank you, Dannion.

MR. BRINKLEY: I am leaving this for you, Steve and Jim, and you two can fight over it.

DR. GORDON: We look forward to sharing it and using it in a complementary way. Thank you.

[Laughter.]

DR. GORDON: Boyd Landry.

MR. LANDRY: I want to thank the Commission for, again, having me before you. I think one of the most important concepts, beliefs, and principles that you really need to keep in mind, and I think Dannion touched on it a little bit, is you don't want what you produce to

be used against CAM in whole or in part by any force, whether it is the government or industries or what have you.

That is probably the most important thing that I can say to you today, is whatever you report to the President in its final form, not be used against any part of the CAM profession, whatsoever, because you will have imploded the CAM phenomenon from the middle out. That is the most important thing I needed to say.

Health care is divided into three parts, the government, the consumers, and the practitioners, and they all have fiduciary responsibilities. The government is responsible for providing a mechanism and a pathway that allows consumers and practitioners to exist. Consumers obviously have a responsibility that is both personal and financial. Practitioners have an ethical responsibility to provide good service. You cannot legislate ethics and morals, no matter how hard you try.

Public policy in the field must strike a balance between these three components, the freedom of consumers to choose, the freedom of practitioners to practice, and government's responsibility in its public protection

aspect. You must resolve what is more important, access or public protection. Protecting the public can minimize access, and open and free access can disrupt public protection. Consumer freedom cannot be maximized without practitioner freedom.

Money is not a true barrier to access. If you believe that is true, then we would have already seen a plateau and a decrease in the amount of money being spent on CAM products and services. Instead, the figures are rising exponentially year after year after year. Insurance equates with control. Providing coverage and insurance equates to control, ultimately. When you look at the way the system is set up, it is a control-based system.

So I encourage you to look outside the box.

MS. CHANG: Sorry, you are out of time.

DR. GORDON: Thank you very much.

Steven Waldstein.

MR. WALDSTEIN: Hello. I am the president of the North American Society of Homeopaths, known as NASH. I thank you for allowing me to speak today.

Homeopaths come with many backgrounds. Some are

first licensed in another field, as an M.D., a D.O., a chiropractor, a naturopath, or an acupuncturist, but most homeopaths come directly to homeopathy. These are known as professional homeopaths.

To become registered as a professional homeopath with NASH requires getting a good homeopathic education at one of the homeopathic schools in this country, and taking a difficult all-day exam to show that one understood that one was taught. It requires submitting five case studies of clients with chronic problems which show a clear, significant improvement to demonstrate the ability to practice homeopathy at a high level.

Candidates must have at least one year of training in anatomy, physiology, and pathology to recognize the warning signs which would trigger a referral to a medical professional. A professional homeopath must meet continuing education requirements and agree to meet NASH standards of practice, including a strict code of ethics. Falling below these standards can trigger loss of certification.

NASH works closely with the Council for Homeopathic Certification, known as the CHC, in setting

these standards, and NASH is actively involved in the ongoing process of establishing national certification by our participation on the CHC Board of Directors with licensed homeopathic groups in order to establish standards of competency for all homeopaths.

The vast majority of serious, well-trained homeopaths are not licensed in another medical field. There are good homeopaths with every background, but the majority of the top homeopathic teachers and directors of homeopathic schools in the United States are professional homeopaths, are licensed.

We practice because we love homeopathy and we are helping large numbers of clients who are not receiving help elsewhere, but we are taking a risk every day, except in Minnesota where recent legislation has opened the doors to many kinds of holistic practices. We are taking a risk in practicing our healing art because of the ambiguous legal status of the practice of homeopathy.

The free market is addressing the situation. Consumers want access to homeopathic care, and most homeopaths have long waiting lists. A small but growing number of insurance companies have decided to cover

homeopathy and are accepting the NASH CHC standard as their standard for good quality homeopathy.

A number of insurance companies are offering malpractice insurance to professional homeopaths and set their rates quite low due to what their research shows is a very low risk factor, but the laws in this area lag behind, keeping the public from having full access to quality homeopathic that they desire.

In the handouts that were handed to each of you, I gave a lot more arguments that I couldn't do in this time frame, and also some supporting documentation. Thank you.

DR. GORDON: Thank you very much.

Deborah Glancy, please.

MS. GLANCY: I would like to thank you for letting me speak, and I apologize that I don't have copies. I will e-mail copies of my comments. Thank you very much for your time.

I am here today as a private citizen, and I would like to speak very briefly about my experiences as a frequent patient of acupuncture and Chinese herbal medicine. I have been treated for 15 years for various

conditions, from allergies to a severe viral infection contracted overseas that kept me out of work for nearly a year.

As a New Englander and daughter of a chemist, I come from a background rooted in both skepticism and pragmatism. I therefore came to acupuncture initially as a last resort. The first chronic so-called incurable condition I suffer from had been treated by Western medicine with little success. The problem was becoming so intrusive in my life that I decided that I had nothing to lose by trying something different.

Since an entire nation had been treated by acupuncture for centuries, I figured it wasn't some flaky, fly-by-night operation. The relief I sought did not come immediately, but after several treatments, I found that the symptoms had abated. Since then, this condition has not completely disappeared, but it recurs so infrequently and so less severely that it is no longer a problem.

Most recently, I was diagnosed with another chronic condition that threatened to seriously effect the quality of my life. When I heard the word "incurable," I turned again to my acupuncturist for help. Again, after a

few treatments, my symptoms disappeared. While the condition can still flare up while I am under stress, it is not the persistent daily problem and incurable disease the reception at the doctor's office had so darkly predicted.

Finally, the best thing that acupuncture and Chinese and herbal medicine helped me with getting pregnant and giving birth to two healthy babies, both born when I was well over 40 years old.

While I am an avid fan of acupuncture, I have also found that it is not always effective. It has not been particularly helpful for chronic sinusitis or my back pain, which actually hurts now. It has therefore been my experience that both Eastern and Western approaches to medicine complement each other quite well.

The biggest problem I have when I go to the acupuncturist is getting reimbursed by my insurance company. I know there is some question on this, but getting the insurance to pay for it is what I mean. Over the years, I have had different types of coverage. Some companies covered acupuncture only if you had a referral from a Western doctor. Some covered it only for treatment

of chronic pain, and some do not cover it all.

I currently have to pay out of pocket for every visit. Although both the office visits and the herbal medicine are less expensive than their Western counterparts, they do add up. It seems impractical that insurance companies often refuse to pay for a more effective, less expensive treatment while they are willing to pay for a less effective, more expensive one.

I am fortunate to have ready access to acupuncture because I can afford to pay for it now, but I haven't always, and not everyone is able to do so. Therefore, I respectfully beg, implore, entreat, and request that acupuncture and traditional Chinese medicine be covered just as Western medicine is, so that we, the consumers, can all have equal access to the best and most cost effective treatments available, whether they are on the cutting edge of technology or centuries old. Thank you very much.

DR. GORDON: Thank you.

Susan Delaney.

DR. DELANEY: My name is Susan Delaney. I am a licensed naturopathic physician, and I practice in an

unlicensed state, the State of North Carolina. I have been there for 14. My background is in nursing. I am an intensive care nurse. I serve on the advisory board, at Duke, of the Integrative Medicine Department, and I am also on the UNC/NIH grant, which is developing a curriculum for the faculty, the students, and the residents in alternative medicine or CAM.

I would like to offer a solution to your licensing issue. It is in the form of a Title Practice Act for naturopathic doctors, and this would be applicable to all CAM providers, which creates a title, sets standards, requires accountability, and eliminates these turf battles.

So, unlike a practice act, where you protect the practice itself, it is a title protection act. This would address your number one goal, which is to ensure the availability of safe and efficacious services. So you could have this freedom of choice with accountability.

Now, let me give you an example of what has happened in North Carolina of 1999, BlueCross/Blue Shield instituted a discount plan in which they were going to cover naturopaths and homeopaths. You had to be

credentialed by having a four-year degree program in naturopathy, you had to pass a national exam or state exam, and also have malpractice insurance.

Within six weeks of instituting this program in North Carolina, the North Carolina Board of Medicine wrote a letter to BlueCross/BlueShield and said, you must cease and desist immediately, at which point they did, appealing this decision and asking that they reconsider.

Well, BlueCross/BlueShield redecided in March of 2000, to reinstitute their plan, at which point the Board of Medicine called their lawyers, and they had a discussion, and it no longer can provide this discount program in North Carolina. So access has been limited because there is no licensing. So we decided to go to BlueCross/BlueShield and ask for licensing.

You will see a letter in your little packet that I provided, and in paragraph 2, it says, that it is crucial that all patients have assurances that the medical professionals that they see meet basic quality standards to ensure their safety.

Which brings me to another point. North Carolina currently is a state where, it is don't ask;

don't tell. It is a free-for-all in North Carolina. In your packet, you will also see there are three cases that I have presented to you. One is the case of the death of a child. These indictments for the man who claimed to be a naturopathic physician coming from a mail-order degree, untrained. The other case is one of a woman in a coma. It is in the back, and also the third case of a child severely ill after being treated by an untrained.

So their argument is that these people only advise and counsel, and they use herbs and what not, but they do call themselves doctors of naturopathy. The North Carolina Medical Board does not think that this --

MS. CHANG: I'm sorry, you are out of time.

DR. DELANEY: So they do not know how exactly to apply that. I do have some bold recommendations for your commission, and I would like, if you have questions, to answer them.

DR. GORDON: I am sure we will come back to you in time for questions.

Anita Mishra-Szymanski.

MS. MISHRA-SZYMANSKI: Thank you very much, Mr. Chairman and members of the Commission, for giving me an

opportunity to say a few words.

Again, my name is Anita Mishra-Szymanski. I am the managing director of AOAC's official methods and peer-rarified methods, analytical programs at AOAC, and I am also the staff liaison to an AOAC dietary supplement task force.

Unfortunately, I was not able to give out copies ahead of time, but they are coming around now. The dietary supplement industry and regulatory agencies agree that rigorously validated analytical methods from botanicals and other dietary supplement products are needed if consumer confidence in the quality of these products is to be gained.

In addition to improving the quality of these products, we need to protect the public health and safety. Since the passage of the Dietary Supplement Health and Education Act in 1994, a large number of new botanicals and other products have entered the U.S. market.

Questions that arise are: What methods are available for the analysis of these products; how good are these methods, and have they been validated. In addition, how do we know what and how much is in the bottle, and

does the content meet label claims; how can we be certain that products meeting label claims are the only ones being used in clinical trials; how can physicians be certain that they are prescribing the appropriate dosages of these products if we do not know if the labels are correct.

The weak link and the theme that you see in these questions is the need for rugged and rigorously validated analytical methods. To answer these questions, and under the umbrella of the AOAC International, AOAC has, in collaboration with the U.S. Food & Drug Administration, and the five trade organizations: Medical Herbal Products Association; Consumer Health Care Products Association; National Nutritional Foods Association; Council for Responsible Nutrition; and the Utah Natural Products Association; U.S. Pharmacopeia; NSF; International Consumer Labs; National Institutes of Standards and Technology; Bureau of Tobacco, Alcohol and Firearms; NIH, National Institutes of Health; Medical Herbal Pharmacopeia; and many other interested parties, have formed a task force on dietary supplements.

The purpose of this task group is to identify dietary supplements, identify analytical methods that

currently exist for these ingredients, and assist AOAC in validating these methods. This would lead to a compendium of reference methods for dietary supplements.

AOAC International is a 501(c)(3) not-for-profit organization, and cited in the U.S. Code of Federal Regulations under Title 21. It is the policy of FDA and its enforcement programs to use methods of analysis of AOAC International where available and applicable.

AOAC is internationally recognized by CODEX, ISO, and IUPAC for being leaders in analytical methods validation for 120 years. We plan to work with all stakeholders, including industry, to provide these methods, as we have for 120 years.

MS. CHANG: I'm sorry, you are out of time. Thanks.

MS. MISHRA-SZYMANSKI: Then there are recommendations on the back page for methods validation. Thank you.

DR. GORDON: Thank you.

Questions from Commissioners? Linnea, please.

MS. LARSON: I am sorry, but I don't remember your name, the naturopathic physician, Susan?

DR. DELANEY: Susan Delaney.

MS. LARSON: Would you mind clarifying what your recommendations are, since you didn't have that opportunity?

DR. DELANEY: Yes. I think you should make some goal recommendations. I think this Commission has the possibility to put out a study that just collects dust. I think that -- let me get them right here -- I think one of the most important things you can do is bring to these professions some of the highest standards of excellence.

So go to the naturopathic schools, go to the Ayurvedic schools, go to California where some of the best homeopathic schools are, go to the National Center for homeopathy and say, what can we do to elevate your standards of education for physicians, for nurse practitioners, for physician assistants, and help these schools. They need help.

Then you can take those programs, not only to these other practitioners, but take them into the universities, have a collaboration. The University of Arizona, the University of North Carolina is considering doing something like this, post-graduate programs in

homeopathy, in naturopathic medicine, in Chinese medicine, Ayurvedic medicine.

I just read over the Internet, where the State of California just approved, it is called the American Academy of Complementary Medicine, programs in Ayurvedic and Chinese medicine, and homeopathy. So it is moving forward, but I think you have to help them provide the funding and bring their standards up, because I think what you don't want in this country is complementary care to be provided by people who have vested interests in vitamins and have mail-order degrees.

Would you go to a mail-order dentist or an M.D.? No. So that is my recommendation, is that you provide funding for them.

DR. GORDON: I am still not quite sure. Funding for?

DR. DELANEY: So you would go to these schools, the naturopathic, the Ayurvedic, and the Chinese medicine and homeopathic. It is clear that you want to increase funding. So if you to University of Arizona or University of North Carolina, you can provide programs.

Nurse practitioners and PAs are dying to learn

this stuff, and they need loans, they need assistance, they need programs that are not flaky.

DR. GORDON: Thank you.

Other questions. Wayne?

DR. JONAS: I just wanted to point out, and unfortunately, Mr. Landry is not here, but that there actually leveling off in several areas of CAM of purchasing, especially in the herbal things that have gone up. It actually has leveled off.

I had a question for Mr. Waldstein about the CHC. What is the relationship between NASH, CHC, and the DHT program?

DR. GORDON: Tell us what those initials stand for.

DR. JONAS: Yes, and please tell us what those initials stand for.

MR. WALDSTEIN: There are basically certification groups in homeopathy. One certification group is the DHANP, Diplomate Homeopathic Academy of Naturopathic Physicians for naturopaths who go on to become specialists in homeopathy.

There is the DHT for medical doctors or

osteopathic physicians, who, again, go on to become homeopaths and get certification.

There is RSHom, which is what I have, a Registered Society of Homeopaths North America, which is NASH's certification, which is now open to everyone.

And there is the CHC, Council for Homeopathic Certification, which gives us CCH certification, which is also open to everyone.

At this point, NASH and the CHC are working incredibly closely together and the standards are identical, our standards of practice are identical. At this point, the CHC is a certification board, and then we are the profession association.

We are working carefully to try to get the naturopaths and the M.D.s to come on board, and all have one combined standard, both standards to become certified, and also, standards to meet once you are certified. So that is what we are evolving toward.

DR. GORDON: Thank you.

Other questions from the Commissioners? Yes, Ming.

DR. TIAN: I have a question for Anita. You

mentioned that analysis of herbal product. Also, in your recommendation, you mentioned you needed government support, financial support to establish methods.

May I ask you a question? One, what can you do for the herbal product? What is your analysis?

MS. MISHRA-SZYMANSKI: What we are trying to do is develop analytical test methods for, maybe, the active component or ingredient within the botanicals or dietary supplements for both the raw materials, extracts, and/or finished products. So we are working with both government agencies and industry to develop these analytical methodologies.

DR. TIAN: So you have not established yet.

MS. MISHRA-SZYMANSKI: That is correct. Right now we have one in the pipeline, and we have a couple that are approved, but there is still a tremendous need for rigorously validated analytical methods.

DR. TIAN: You mentioned that you need about $30,000 to $100,000 establish the one method, one single method. So, if all the herbs need a study, can you give me a number? For instance, how many analyses will be available, will be reasonable that as consumers, we must

know.

MS. MISHRA-SZYMANSKI: I am not sure I completely understand.

DR. TIAN: How many methods do you think you need to establish?

MS. MISHRA-SZYMANSKI: I mean, they will be numerous. There are so many products out on the market. There are raw materials, there is extract, there might be roots. If you look at the range of botanicals, one method may not be applicable to all. So we will need a whole series of them.

Right now, the Task Force has only identified those 18, and that is just a starting point. That is just the tip of the iceberg that we have to work on.

DR. TIAN: For 18 dietary supplements.

MS. MISHRA-SZYMANSKI: Ah-huh.

DR. TIAN: That means components, active components?

MS. MISHRA-SZYMANSKI: Raw materials, yes.

DR. TIAN: Can you identify the 18? What are they?

MS. MISHRA-SZYMANSKI: Sure. In the leaflet

that is attached to the memorandum, on page 3 it outlines the 18 that we have identified.

DR. TIAN: Thank you.

MS. MISHRA-SZYMANSKI: You are welcome.

DR. GORDON: Other questions from Commissioners?

[No response.]

DR. GORDON: Thank you. Thank you all very much for coming and sharing with us. We are going to be adjourning this meeting now. Once the Interim Report has been presented to the Secretary, and gone through channels, and is ready to be presented to the President and Congress, at that point we will have it available on our Web site, and everyone will be able to see it.

The next meeting of this group is going to be October 4th, 5th, and 6th. We have added a third day because in that October meeting we are going to be looking at a number of different issues that we have addressed but not fully covered in the meetings up until now, and we will be going over those issues in preparation for making recommendations in the Final Report.

Other remarks before we close? Wayne?

DR. JONAS: Item H, in the Interim Report was

not discussed at all, and it actually makes one of the strongest statements.

DR. GORDON: That is true.

DR. JONAS: And I would suggest that, before the Interim Report goes together, that that section be circulated specifically for comment to all Commissioners, so that we have a chance to have some input on that.

DR. GORDON: Thank you very much, Wayne. You are absolutely right about that, it was not covered.

Any other final comments, questions?

DR. JONAS: [Off mike.]

DR. GORDON: No, that has been changed. It is October 4th, 5th, and 6th. Thank you for bringing that up. So it will be Thursday, Friday, Saturday for that meeting.

Okay, thank you all.

DR. JONAS: I want to thank you and I want to thank the staff for the flexibility they have shown in our altering of the agenda this time. So I want to appreciate them.

[Applause.]

[Whereupon, at 4:32 p.m., the meeting

was adjourned.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE THE: White House Commission on Complementary and Alternative Medicine

HELD: July 2-3, 2001

were convened as herein appears, and that this is the official transcript thereof for the file of the Department or Commission.

DEBORAH TALLMAN, Court Reporter