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on
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Volume I

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Conference Rooms C & D
6001 Executive Boulevard
Bethesda, Maryland

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# C O N T E N T S

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

[8:07 a.m.]

DR. GORDON: I would like for us to begin with a moment of silence and this time, in the silence, to use it as a moment for remembrance for those who lost so much in the events of September 11th. So, if we could all just sit in silence and in solidarity with them.

[Moment of silence observed.]

DR. GORDON: Thank you. Thank you all very much.

**Opening Remarks**

DR. GORDON: Just a couple of things to begin with. One is it seems to me that our work, always important, takes on a whole new dimension in the light of the kinds of healing that we all, and all of us as part of a nation, need after the events of September 11th.

What we would like to do is on Saturday morning, we will set aside a little bit of time, if there is specific thoughts that people have about the contribution that CAM might make to the general process of healing in our country, and we can focus on that on the 11th.

I wanted also just to say how grateful I am to all of you for being here. I think it is really important that we are here and that we are together, and that we are here in the Washington area at this time. It is a very important statement about the importance of our work and about how healing and help is so necessary right now.

The other thing I wanted to say before Steve goes into the order of how we are going to proceed is, as some of you know, I was out of the country. I was actually in the middle of a war when this war began over here. It was very strange being in Macedonia and then coming back here.

One of things that I appreciate so much is all the work that everybody has done in preparing for this meeting, all the Commissioners and all the staff. It is just an extraordinary document that we are going to be working with these next three days. I am terribly grateful to everybody for all the work that everybody put into it.

Steve is going to talk about how we are going to move through the next couple of days and then we are

going to move through quickly, and Michele is going to be keeping us on time, all of us, very strictly on time as we move through.

Steve.

DR. GROFT: Good morning, everyone. I would like to express my gratitude for you all willing to come back and join us. I think we were prepared to have a teleconference, but once we heard that everyone was able to attend, we just did away with those plans, so thank you very much, I really do appreciate it, especially also for your work.

Since the Interim Progress Report, which as I mentioned in an e-mail to you was signed off by the Secretary last Friday afternoon, and we have copies of it at the desk and we will be putting it up on our Internet site to make it available for comments, and anything that anybody would like to respond to that, your friends or colleagues, just ask them to send us a note, and we will communicate that information to you, as well, so I do appreciate it.

I just want to mention, two other people who are in the room, Mary Plummer and Mandy Stoneberger, a

couple people from our Committee Management Office, if you want to stand up really briefly.

They ask you to update your files as far as conflict of interest and everything else. It is not a matter of them wanting to know everything that is going on, and this information is confidential, but we need to know where funds come from, where your support is coming from, so if anyone raises an issue we can say yes, we know about this and you are cleared as a member of the Commission.

We don't take these things lightly. We just never know where people will be asking us, when they will be asking us for information about the Commission. We had this early on about the membership, so I would ask you just to please update the requests that are provided to you on a regular basis. Usually, it is at each meeting.

I think as we approach the meeting, especially as we have completed the Interim Progress Report, we were looking at how would we pull this meeting off, how would we begin to write the Final Report, and there were two possible approaches that we thought about and normally

you would go through I guess.

One is to write the report and then develop the recommendations. The other way is to develop the recommendations and define the issues, and then write the report. I think after the whole process of going through and preparing the Interim Progress Report, we thought that we needed the foundation on agreement with the issues and recommendations, and that is why I think we took the approach we did of trying to define issues and recommendations that we could discuss at this meeting, develop some of the background information for the Final Report, although the background information that you received and is in front of you really is the rationale for the recommendations.

That may change, and probably will change, as we go through the next three days as we being to prepare the final report, at least the Draft Final Report, for the December meeting that we will be discussing at that point in time.

So, we will be picking up maybe more appropriate examples, better ideas, better concepts, so this is fluid and it will remain fluid until we have

final agreement on the part of the Commission either in December or perhaps at a later meeting depending on the progress that we make.

We ask you not to focus so much on the language in the text of the background information, but we really want to focus on the issues and recommendations that are before you.

The workgroups will continue to function as they have. They will be responsible for developing that section of the Final Report that they are currently working on. So, it is going to carry through until completion, so each of the workgroups will maintain their status and their activity level.

People have said can we change, we prefer that you don't, but if someone wants to join another group, they are welcome. I think you all realize how much work is involved with each individual group, especially the facilitators, so I don't know how many people want to take on an extra burden of an additional workgroup, because it has been a lot of work.

Today, tomorrow, and Saturday morning, we tried to break out each of the sessions into two-hour periods.

We will open up with a 10-minute introduction by the facilitator or co-facilitators, talking about the process, how they got to where they are, some of the remaining issues that are problematic. These are the types of things that will be brought out.

We then will have five minutes to go around to the other workgroup members to see if they have anything additional to add to what the facilitators mention in the introductory comments.

Following that, we will move into about a 75-minute discussion of the issues and recommendations that are before you. We will just sort of run through and see if there are areas of agreement or disagreement, and then we will take it from there.

I will be passing out a little bit of a cheat sheet here that has all of the issues, the time frames, and then the disposition of the issues and recommendations.

After the discussion, we will have about 30 minutes that Jim will take to take care of the recommendations and the issues, and we will be asking you to make some decision whether to accept the issue or

recommendation as presented, accept it with change, return the issue to the working group with all the discussion that we have, delete the issue of recommendation.

There may be some of the recommendations that you want to knock out, and not include, or determine that it shouldn't be the status of a recommendation, they may not be worthy of that as far as emphasis.

If there are new issues or recommendations, and we think there will be, we ask you to limit your discussion of that issue, that new issue, a very, very brief discussion. We have time on Saturday morning to pick up and discuss in greater detail the new issues.

We only want to get them on the table now. Our concern with the very limited amount of time is if we spend a lot of time working on the new issues, we will never complete the recommendations that are presented. So, I think what we would like to have is, raise the issue, your brief rationale for your concern, state it, and then get out. You know, we are finished with it for now. We will bring it back. The workgroup, then, will address that as they prepare the draft of the report.

So, I think we have to rely upon the workgroups to do their work, and they will be in touch with the individual who raised the issue or the concern.

So, I hope that is okay. We just are reluctant to spend 10, 15 minutes out of 75 on a new issue, that the workgroup really needs to hear from you and then expand a little bit in their procedures.

So, I ask you to be patient and let the workgroup do their thing after this meeting to bring this to completion for you.

I think that is about it. I apologize for some of the confusion, but we have to be out of here at 5:00 both days. It is security, added security. They are closing government facilities at 5:00 for meetings, so we will be bumped out of here.

What happened, also, we tried to get the meeting at the Pooks Hill Marriott for Saturday morning. They had no meeting room, so we are going to what is called the Marriott Suites Hotel over on Democracy Boulevard, not real far from here, and we will make arrangements again to get you out to the Marriott Suites Democracy Boulevard location, which is a breezeway walk

over to our offices.

Once we heard that we didn't have the Pooks Hill Marriott for meeting space, we ran over there, and they fortunately had a space for us to meet. So, my apologies for the confusion on that Saturday. Again, that is quite accessible to the interstates and to the airport, so it will be a little bit easier I think in the long run.

On Saturday morning also, I will talk about how we are going to prepare the Final Report. We have procedures in place to continue utilizing the workgroups, and all of that will be discussed on Saturday morning. A couple of you I think have to leave, and we will make sure you get a copy of what we will be talking about at that point in time.

DR. GORDON: Thank you, Steve.

Let me just make sure that everybody is on the same page with how we are going to proceed. If there are any questions about that, we can deal with them now.

The basic idea after the presentations by the workgroup facilitator and by any additional comments, and after any additional comments from workgroup members, is

that the major discussion of all the recommendations will take place in that next 75 minutes.

The final 30 minutes is -- and that will be led by the facilitators -- the final 30 minutes is to make sure that we are all on the same page as we move ahead, and that part I will facilitate.

My job is just to make sure that we have heard each other correctly and that we agree about where we are, and that we put a recommendation into one of the categories that Steve mentioned, that Ken has listed up on that board, that either we accept it or we change it, there is a new issue, we decide we don't want to make that recommendation, et cetera.

So, I am going to ask a question at that point, which will worded something like can we live with this recommendation, and if we can, then, we will put it up there in that category; if we can't, it will go back to that workgroup.

So, this is a continuing process. If we decide we can't live with the recommendation, then, it is up to the workgroup to keep on working with it, and working with whoever has issues or concerns.

One of the things that Steve said that I think is important to emphasize is if you have concerns or issues about any recommendation, the workgroup will be available to you, but we really want each person who has those concerns to get in touch with the workgroup facilitator and to make those concerns clear. Okay?

So, if there is an issue, let whoever is in charge of that particular workgroup know about the issue, so they can grapple with it and if you have new information you want to bring to them.

Once again, if there are new issues, new possible recommendations, we will just raise them and then come back to them on Saturday morning.

Any questions about the way we are going to proceed for Steve, me, or Michele, or anybody? Michele.

MS. CHANG: I just want to mention as we start each new topic, we are going to ask the facilitator or facilitators and the staff lead to move from where they are sitting now to that table there, so that everyone can see them clearly. Take your name plate with you.

DR. GORDON: Just one thing about my role. In the early discussion, I am a member of the Commission,

the facilitator is in charge, and then I will step back and my job is to help make sure we have the recommendations as everybody wants it in the final 30 minutes.

MS. CHANG: I am going to start the clock at 90 minutes for the full discussion, which includes your 10-minute overview and member group around the table, and I will give you a 10-minute warning when you need to start summing up to get ready for the disposition.

Thank you.

MR. CHAPPELL: Would you repeat the time sequence?

MS. CHANG: Yes. I am going to set the timer at 90 minutes, which includes the 10-minutes overview and the 5-minute comment by other members of your workgroup before you move into the full discussion. I will give you a 10-minute warning, so that you know that you need to start to summing up.

MR. CHAPPELL: Great.

**Session I: Definition of CAM**

MR. CHAPPELL: Good morning, everybody. This particular session is on the definition of CAM and the

guiding principles that we commissioners have crafted as a way of helping our readers, our audience understand how we oriented to the topic in a kind of world view perspective.

I am going to help us through the section on the CAM description and definition, Dr. Jones will help us with the guiding principles, and Jim Swyers, the writer of the material, will contribute as he wishes.

I want to thank particularly Jim Swyers for the great work that he has done for this group, this committee. It has not been an easy topic, trying to get our hands wrapped around the definition of CAM has not been easy, and I just want to thank Jim for his good listening and good encouragement and good drafting for us.

I also want to thank our committee for the time and attention, thought, and guidance that each has given on this process.

With that as way of introductions, shall I proceed with my piece? Fine.

DR. JONAS: Tom is going to go through the definitional issues, I am going to go through the guiding

principle issues, but we are all in part of this together.

MR. CHAPPELL: Great. In looking at the definition of CAM, I will be referring us all to pages 1 through 6. The structure of our dialogue will be built around basically describing CAM, speaking about the marginalization issue of CAM, talking about the differentiation of the different practices of CAM, some of the common characteristics of CAM, and then looking at a summary definition of CAM. So, that is the structure of my portion for us.

Why don't we begin then looking at pages 1 and 2 as we look at the while question of describing and defining. We tried to say let's define CAM, and throughout our sessions over the last year and a half, this has been a provoking question, are we all talking about the same thing here, or do we really need to come up with a definition.

So, my thanks to those of you that have been probing and forcing us to wrestle with this. As you can see by our attempt to define CAM, it began with a description of CAM. It is just too broad to wrestle to

the ground that simply, so we have let ourselves cast the net here with being sure that we are touching down on all of the points that we need to in describing CAM, and that is what you have before you.

It is a diverse set of both ancient and modern health care systems and practices. These systems and practices, not always supported in the Western countries, focus on the support and stimulation of the healing processes and on the whole person care to prevent and treat illness.

The health care system and practices are shown on the following table, and there you see the diversity in the chart and have gained increasing acceptance and recognition by mainstream health care. This is our attempt to circumscribe the various modalities and practices.

Before I move on to the marginalization section, could we have some discussion?

DR. JONAS: I just want to mention this definition. Just to kind of reorient you, I think we have talked about this before, there have been multiple different definitions that have come down through the

years and we had in our discussion and certainly in our subcommittee we saw many of these.

Jim put together a very nice kind of summary list of definitions that have come over a number of years. This one is one that has been pulled from, and modified slightly from, the Cochrane definition, which in turn was pulled from an OAM definition working committee on definitions back in 1995. So, this is kind of the link to this particular one.

This had input from a number of international groups, so it was felt that this was important that this be something that would have worldwide applicability or at least the potential to have worldwide applicability in those areas. So, that is just a little bit about the history and the background of that.

MR. CHAPPELL: Great. That is helpful, Wayne.

Tieraona?

DR. LOW DOG: Just a couple thoughts. Especially given the state in the United States and how we are going to talk about dietary supplements and that, complementary and alternative medicine is a diverse set of both ancient and modern health care systems practices

and products.

I do think that in many cases, people are using dietary supplements without the context of anything, and I think it is a multibillion dollar business in this country, and I think products may be appropriate there.

The other thing is, these systems and practices which are not usually available or supported in most Western countries. I am not sure I know what we are trying to say, but it is not really accurate when you consider that osteopathy, chiropractic, naturopathy, homeopathy, therapeutic touch, applied kinesiology, and relaxation therapy really developed in the West. That is their origin. That is where they came from. Spiritual healing, nutritional therapy, aromatherapy, and herbal medicine are really worldwide.

I think what we are trying to say there is that it is not supported often by the dominant systems within Western countries, but to say that they are not available, when that is where they came from and they still flourish, I think is somewhat misleading.

Those were my only two comments.

MR. CHAPPELL: Thank you very much.

Yes?

DR. PIZZORNO: Actually, I would just like to start with a general comment. On the long cross-country flight, I had a chance to sit down and read this document in one sitting in its entirety.

I actually would like to compliment the staff and the commissioners for an incredibly well-done job. This document is very, very impressive. If I had my druthers, I would say I move to accept and let's all go home.

[Laughter.]

It is still 5:00 in the morning for me. I would also like, as a comment, to second Tieraona's insightful comments. Indeed, many of these did arrive from the West and I think there needs to be some tweak in the language to recognize that.

Thank you.

DR. JONAS: I just want to say there is no word originated from in this, Tieraona. Maybe we want to change tweak the readily available or something like this, there is no statement in here about that they did not originate from.

DR. LOW DOG: My comment, though, is that I think it is somewhat misleading or not usually available. I mean chiropractic and osteopathy are readily available, therapeutic touch is readily available, herbal medicine is across the board in the United States. I mean you can buy it at any health food store or Wal Mart.

Spiritual therapy goes on in churches every day all around this country, so I think it is a bit misleading. This comes back to the problem again about when you are saying CAM, some of which are not supported by the dominant systems or medical systems of Western countries.

I think that what we are really talking about is not so much availability as the acceptance of them, and that is what leads to marginalization.

DR. JONAS: I think availability is also part of it. I mean access is a whole section that we are talking about, so it is certainly not one that we would take out.

We had in the original definition from the OAM, and actually, Cochrane I think maintained it, the word "dominant" meaning the politically dominant, and I think

it was stated "politically dominant," was part of the definition, which the committee decided we wanted to alter or remove.

Is that reasonable? I mean am I hearing that we should insert that back in?

MR. CHAPPELL: Dr. Gordon.

DR. GORDON: Wayne, one of the things that might help address some of your concerns, Tieraona, is to have more of the history and the background to give a sense of where the different perspectives and where the different practices are coming from.

I agree that the definition needs to alter slightly to accommodate these concerns, but if we provide a sense of the development of some of these modalities and how they have entered into the world and the United States, not a huge treatise, but some background, I think that that will be helpful in helping us understand where we are in this issue.

MR. SWYERS: One of the main pieces here that we have talked about is doing a history like that, and I think that will help inform some of the language in this, but I think right now we need to focus on the major

pieces, because this is kind of different than the other sections, we are actually reviewing text, but I think now we need to focus on the major chunks and then we will go back and we will wordsmith this.

As we see those other pieces fall into place, it will help inform our definition and some of our descriptions.

MR. CHAPPELL: Go ahead.

SISTER KERR: I would like to request, Wayne, Tieraona started speaking, I think it might benefit us to read that definition that included the politically dominant and why we perhaps thought it might be a yellow flashing light to the listeners.

The other thing is, is it appropriate to point out that we have another summary definition of CAM on page 6?

MR. CHAPPELL: We are coming to that.

SISTER KERR: Just because of where people strayed, thank you.

MR. CHAPPELL: Thank you. I would like to take as a guideline to any edits to this work, that we simply ask ourselves whether a specific phrase or word choice,

whether it needs to be there at all.

I think if we are going to be building the case for the history and including that, that history section will speak for itself, but when we get to the actual description or definition of CAM, I think we have to ask whether or not that language needs to be there at all.

In the case of the phrase "which are not usually available or supported in most Western countries," I just don't think that needs to be there at all.

So, that is kind of the way we can comb without asking the Commissioners to wordsmith this from here, I am just giving us some guidelines of if there is going to be a history section, and there will be, perhaps some of this can drop right out and we just get the focus right to what it is we do, what is it we are all about.

Go ahead, Joe.

DR. FINS: Thanks, Tom. I want to just piggyback on what Charlotte was getting to because I think that her flashing forward to page 6 is I think relevant, because I think this definition is more of a historical conception, and what you have on page 6, which

we will get to and I don't want to discuss now, is probably more reflective of what we all believe.

So, I think that the reason why you have the dominant, and you were trying to do the history and go forward at the same time. So I think if we simply said the prevailing views from Cochrane, and the earlier reports, viewed CAM as blah-blah-blah, because if we go to page 6, which we are not going to get to, it is a more integrative tone. This is more dualistic and antagonistic and defensive. So, I think we have evolved to page 6.

This is a historical definition, and not necessarily a definition that we are currently embracing. I think that might be my reading of how it played out.

MR. CHAPPELL: Thank you, Joe.

Yes, Effie.

DR. CHOW: Just onto that statement, I think if we change the word from "usually," like someone suggested "readily," I think available means not only the fact that it is available on the shelves and acupuncture is available, homeopathy is available, and chiropractic is available, but it is available limited because of

finances, as well.

This is what I am interpreting into this. It is not readily available and supported in most Western countries, is that it is not funded, we have to pay out of our own pocket usually for these CAM services or products.

So, for me, I think that is important to keep that in, maybe not "usually," you know, that word. Maybe "readily" is more suitable. Maybe we need to say "financial" in there.

MR. CHAPPELL: I am not accepting edits to the language. What I am accepting is what thought is missing for you, what thought is in the way, what thought is missing for you.

DR. CHOW: This is what I am presenting is that the financial aspect is not apparent in here.

MR. CHAPPELL: Okay, financial limitations is not apparent.

DR. CHOW: Yes.

MR. CHAPPELL: Thank you, Effie.

Tieraona?

DR. LOW DOG: I think Charlotte's and Joe's

comments, I would just like to echo that perhaps leading in, since this is really what you begin to read when you first read the report, I think a non-defensive, antagonistic opening is important, I think for the people that are reading it.

When I read it, and I am a pro-CAM person, I felt I had a lot of disagreements with it, and I am pro. I like the definition on page 6 quite well, and I just want to echo sort of what has been said, just for consideration when we are looking at it.

MR. CHAPPELL: I think we could actually open this section with the summary definition, and I am even asking whether we should be dealing with the guiding principles before we get to the definition, because the guiding principles really are the orientation of the whole report.

My reflections on this are to flip the guiding principles to the very front and then move into the description and definition of CAM, and to everyone's concern here about the summary, in fact, I was going to open our discussion on the summary paragraph because I think that is where the real work becomes focused.

We could open that section with the definition and then proceed from there. I see some heads nodding. Yes, Joe?

DR. FINS: The work that I didn't see anywhere in the whole chapter was "integrative." In fact, the very last sentence of that paragraph, the summary definition, is saying that the lines are getting blurrier. In fact, I think we want to encourage that blurriness a little bit.

There may be a way of trying to say that patients, as we have said many times, patients don't define themselves as CAM or allopathic, they are just patients, and they are going back and forth and the lines are blurred, because they are going back and forth.

So, I think we need to recognize that up front, and that is really the motivation for the entire commission, that people are utilizing it, so the inversion might be helpful.

MR. CHAPPELL: Thank you.

DR. JONAS: I think it is a double-edged sword. Certainly, "integrative" and encouraging the blurriness of the definition is accurate. On the other hand, it can

come back to bite you and that suddenly there is no field called CAM.

Yesterday, I was meeting with some folks at the NIH, and they were talking about all the CAM research they were doing, and I looked at it and I said, boy, this is the stuff that has been going on in the intramural program at NIH for years, but now all of a sudden it is redefined as CAM.

So, I think we have to be careful about being too integrative. We just have to be sensitive to that, because a powerful system, the politically dominant system can indeed swallow up and claim an area without really getting the fundamental issues of holism, of healing, et cetera, and end up kind of focusing on products. This is a new way to look at the kind of products we haven't looked at before. So we have to be a bit careful with keeping the boundaries blurry.

There are some advantages to try to at least be clear about what the core issues are that we want to make sure are unique to complementary medicine, or at least what complementary medicine is providing.

MR. CHAPPELL: I would like to ask the group to

go to page 6 to look at the summary definition of CAM, and then we will work backwards from there.

Go ahead, Joe.

DR. FINS: I take Wayne's point seriously. I think perhaps a diagram right here, Figure 1, might be a Ven diagram, which shows that there are polarities, there are elements of allopathic and CAM medicine which do not overlap, but there is an area in between that does. Very simple; everybody would understand that.

That would also show that we are trying to create in integration while maintaining the differences that are instrumental and valuable to our health care system.

DR. JONAS: I like the idea that one of our goals is to properly integrate, and that puts this kind of blurriness into a positive perspective, I think, a proactive perspective. So I would like to have that term in there.

MR. CHAPPELL: Thank you.

Let's look at the summary definition. I will just ask whether there are any thoughts that are missing there for you or thoughts that are simply not stating it

as you understand it.

Dean?

DR. ORNISH: This may fall into your definition of wordsmithing language except that I think that this particular paragraph, of course, is crucial to the entire document because it is really defining what the rest of the document is about.

When we say that it is other than those intrinsic to mainstream health care, I just want to emphasize that we start by marginalizing ourselves. I think that what I would like to see as a common theme throughout the document is something that we really take the middle ground that says that it marginalizes people who are going to criticize the report.

For example, in our report, what we talk about later, to say that CAM research should be held to the same standards as non-CAM research, no higher, no lower. Well, that is kind of hard to argue with. Then, you force people to say no, it should be held to a different standard, and that marginalizes their argument.

Here, we are in effect, marginalizing ourselves literally by the definition of saying that is outside the

mainstream, when I think one of the reasons that the Commission was formed in the first place was Eisenberg's, and other's, research, talking about how it really in many ways is mainstream.

So, I think those words have such different connotations that we should choose them carefully, and if there is some way that we can say even in the definition that this is something, it is not a question of should people be using this marginalized stuff, but rather they already are in some way even more so than conventional medicine, and therefore, that is why these are worth looking at. That, to me, is what is missing here.

MR. CHAPPELL: Thank you.

Joe?

DR. FINS: Along those lines, it is really a means and ends kind of argument. You know, allopathic medicine, primary care, general primary internal medicine, family practice might have the same ends, but a different means to the same ends. So, that might be a way of overcoming this sort of dualistic or dichotomous language that sets up a false antagonism between the goals of the holistic CAM provider and the holistic

allopathic provider or modality.

This is an aspirational model that applies to different vehicles to achieve the same end.

MR. CHAPPELL: Yes, Dr. Gordon.

DR. GORDON: This is really just procedural. I think that the more that the facilitators, as the discussion kind of comes to a natural end about a particular issue, the more you can sum up what you have heard and where you see things going, the easier it will make it for us to move along, so I am just giving that back to you.

MR. CHAPPELL: Thank you.

Joe?

DR. PIZZORNO: I think one of the challenges we are facing here is a historic perspective where this clearly was way outside the mainstream, and now a more moderate perspective where there is definitely some overlap and some mutual appreciation.

So, I think maybe if we put some historic language in here just for some of the separations, it will help clarify this, because clearly, this did come from outside the conventional academic institution,

federally-funded system that has dominated health care in this country for so long.

MR. CHAPPELL: Great. Thank you.

Tieraona?

DR. LOW DOG: I am going to raise it now because it is going to come up again and again, but when we talk about the major CAM systems, we have never identified the major CAM systems. We listed a whole bunch of systems, but we didn't say these are the major CAM systems, and when we refer in this document to major CAM systems, this is what we are referring to.

DR. JONAS: Do you want to list them?

DR. LOW DOG: Well, that is my problem.

DR. JONAS: It is our problem, too.

DR. LOW DOG: I think if we are going to use the phrase, though, my first question would be, if I didn't know much about this and I am somebody reading this in Congress, I would say, well, what are they; what are the major CAM systems; what are you talking about.

DR. JONAS: You can list some of them very easily, Ayurvedic, et cetera, et cetera.

DR. LOW DOG: Just put them down there then.

DR. JONAS: But the problem with listing them, as you know, is that some are not listed.

DR. LOW DOG: I think we are going to have to deal with it, though. If you are going to use it as the major CAM systems, then you are going to build all these systems, have X, Y, and Z, and they do X, Y, and Z, and they are this, you have to define them. Whether it is difficult or not, if we are going to use the phrase, it is going to have to be defined, because we build an awful lot upon it.

MR. CHAPPELL: I am hearing a lot of comments that are addressing the history of the CAM movement and how that has begun very much in polarity with the Western culture, and yet how that has come to an integrative state in many different modalities today, that there are some that are still not as well accepted or incorporated, but there are some that are very much in the integrative reality in this country.

So, I think if we add history and evolution as notions in our definition, those will help bring about this kind of where we are today and it gets at what it is. I think this is the struggle with this definition,

what is CAM.

I don't mean to belittle all the work that has been done. It is just to say what it is now can be achieved if we offer the historical perspective in the drafting, the evolution to date of specific practices.

Then, quite frankly, we can't describe this unless we are addressing the world view, the very different perspective that we have. This is why I feel that the guiding principles will serve the definition better if they come before the definition, because it helps the reader get oriented to the fact that we are not a group just about illness, we are about illness and wellness. That very difference has set up apart.

So, I would encourage us to flip the order, help us throughout the drafting get clearer on history, evolution, how certain practices have moved from polarities to integration, and then really focusing on what this is.

Those would be my thoughts, Jim, in trying to help identify what I am hearing.

DR. GORDON: What I was going to say is, it might be helpful if we had a sense that what Dean and Joe

in particular were talking about, about focusing on aspiration rather than opposition, if there were some kind of commonality among all of us about that at this point.

I am saying that partly because I agree that I think that that is more important and that the definition is going to be crucial, so we need to be in tone, as well as in the specific words.

MR. CHAPPELL: Good. Thank you.

DR. FINS: Following on what Tom said, I think it is very helpful, but just to put it into a philosophical context, it is very Hegelian. There is antithesis and a new synthesis. That is part of how this has happened. There has been a reaction to, and a moving towards, which is an integrative model.

There are some things that are clearly not intentioned, and are in parallel. So, I think there are really two ways that we got to CAM, and the other thing, Tom, you said what CAM is, but it is also is and becoming, whatever this new thing is.

So, it is a moving target, and I think we have to acknowledge that the very fact of producing this

document changes a lot of definitions. So, it is an evolutionary phenomenon and I don't think we want to be static, and I think it is very much an evolutionary framework.

MR. CHAPPELL: Thank you, Joe. Yes, Dean.

DR. ORNISH: Again, I won't belabor this point, but particularly at the very beginning of the document, to the degree that it is read as a criticism, it is harder, people stop listening.

When we talk about systematic and consistent suppression of CAM professions, et cetera, I mean that just immediately polarizes people and to a degree that I think is really counterproductive, if there is some way we could find a different way to express that.

MR. CHAPPELL: Yes, Tieraona.

DR. LOW DOG: But I think it is important that it is included in the document, because it gives the context to where we are today, so I think that it needs to go into the historical section.

So, my comments would be that I like the guiding principles, that we start with those. They are very positive, and when you read them, I think we are

going to have very little disagreement over them. I think they are powerful. This is who we are, this is the commission, this was our charge, these were our guiding principles, and then we go into it.

You could put the summary of CAM, and then you could give a historical context. I don't think it has to be antagonistic, I think that it can be factual, and it also gives place to how science did bring about very positive changes, as well, but how things through a number of reasons happened and that some of these are considered mainstream and some are not.

I think it is important in the document to have a historical context of how we are, but I think when that is what you open with and that is what you read to begin with, it just is hard to read.

DR. ORNISH: When you talk about systematic suppression, those are strong words, I mean really.

MR. CHAPPELL: Can we hear from Jim for a moment, please. Jim.

MR. SWYERS: I think what Tieraona is saying makes sense. I had not envisioned putting the guiding principles in the introduction of the report, but I think

that might be a better place for them than here. I like the way she laid it out.

DR. YOUNG: Great.

Joe.

DR. PIZZORNO: I have some mixed feelings here. On the one hand, I agree with you, we don't want to be antagonistic, but on the other hand, we have to talk about the historic reality. The historic reality is that the AMA lost an antitrust lawsuit that documented the systematic suppression, and right now, today, the state medical associations are blocking the licensure of other of the CAM professions in states all across this country, so it is happening today.

I don't want to be antagonistic, but let's not pretend that this is not happening.

MR. CHAPPELL: I think these matters can be handled just as we have been speaking. First of all, we open the section with the guiding principles, i.e., world view. Next, we have a description of the history of this as we have been describing it, although we might open that section with the summary definition, but either the summary definition at that point or following, but I

think we can craft this with a different structure and a better focus.

So, I think all these comments are helpful. I am running out of time on my section. I am just going to take your comments here as ways to address more specifically the sections of the CAM material on pages 1 through 6, which are very well identified I think, but we will work on the order of presentation and the tonality without forsaking any kind of accuracy in the history.

MS. CHANG: Tom, just so you know, you have got about 10 minutes for this part of it.

MR. CHAPPELL: Well, but according to what was handed out here, I had only 20 minutes, and I have been 30 minutes so far.

MS. CHANG: I think you have pretty much put the two together, the description of CAM and the summary definition of CAM. So I have given you 40 minutes for that. So, you have about 10 minutes before Wayne's part.

MR. CHAPPELL: Okay. Joe.

DR. FINS: On the point here of showing how we are moving towards integration, I think a nice example, which I would like to see sprinkled throughout the

report, is the role of hospice as a meeting ground for the allopathic and the CAM.

In other words, if we are looking at this evolution and this new synergism that is evolving, that is a nice part of the middle of the Ven diagram is really end of life care and the hospice movement when you are using therapy, you can get massage, you can get morphine, you can get a PCA pump, you can get radiation. I mean there is a lot of things.

So, I think that is an example of how people are kind of coming together in that aspirational model, like on page 5, in that area, we are talking about spirituality.

MR. CHAPPELL: Thank you, Joe. Effie, and then I will take a few minutes just to look at the section.

DR. JONAS: Go ahead. I just want to mention one thing related to what Joe and Dean have said.

MR. CHAPPELL: Why don't you go ahead, then, and then we will go to Effie.

DR. JONAS: I have a suggestion. I like the idea of a Ven diagram. It is a moving target, there is a spectrum of CAM all the way from things that are clearly

antagonistic and outside of mainstream, all the way to things that it is hard to tell the difference, and, in fact, there is no difference.

I would just like to suggest we introduce something like the Ven diagram illustrating the spectrum and illustrating that it is dynamic, that, in fact, it is changing, that there are things that used to be very much outside and that are now much closer, there are things that are emerging, there are things that are completely overlapping, and that one of our goals is to really move these things closer and closer together to have a common understanding and get them into the health care system when they are safe and effective.

I think the idea of a spectrum, especially a dynamic spectrum, which we could then illustrate with a figure, might be a very useful way of doing this, and also illustrating I think, as Dean and others have mentioned, a little more emphasis on the fact that these are being used and that they are actually, at least for the public, already part of the mainstream, which I think needs to be very clear and perhaps up front.

MR. CHAPPELL: Effie, and then Dean, then Joe.

DR. CHOW: I also like the spectrum and diagram aspect, too. I hope the history will go back to reporting on the times in the 70s when people were being jailed, acupuncturists were being jailed, and so it shows the evolution, homeopathists were being jailed and Christopher Hill, the holistic practitioner, was being jailed, and how we have to help them get out of jail, and so forth, to now that acupuncture is being funded, and then the integration like the model that Joe gave, the total integration. So it does give the history of the difficulties that it has come through.

I think we have to remember always, because I think a lot of comment of fear and antagonism is because we think that the Commission Report is coming from us as Commissioners, but we are really speaking for the people, and I think we have to keep that in mind and that we must speak for the people that have spoken so forthright about the prosecution that is still going on.

I think it is our duty to speak to those aspects without talking about antagonism from our standpoint, but from the fact that we have heard this from the people, and we must represent the people from

both ends, from the traditionalists, who want to integrate and don't know how to integrate, and from the people who have been trying to practice and have been indicted, and still find great difficulty.

So, if we keep remembering that we are speaking for the people, and this document isn't from us only as Commissioners, perhaps that might help us from being fearful of speaking what is the truth right now.

MR. CHAPPELL: Thank you, Effie.

Dean.

DR. ORNISH: For me, it is not an issue of being fearful, it is an issue of being what I think is being accurate, and I have I guess what really amounts to a process question, which is, I have pretty strong feelings about this language, "the marginalization of CAM results into the systematic and consistent suppression of CAM professions, institutions, and practitioners by mainstream health care professions through a variety of political, institutional, and economic means."

That is such inflammatory language, and I don't agree with it. I mean, there are certainly examples, as Joe Pizzorno has pointed out, and we will agree to, I

have certainly had my own experiences, but in terms of making it so sweeping, systematic, consistent, I don't agree with that.

So the question is, if one or more Commissioners has a minority point of view that he feels strongly about it, I am not quite sure what the process is at this point.

MR. CHAPPELL: Dr. Gordon, would you comment on that?

DR. GORDON: My perspective is, I agree with both sides. I think there has been some systematic oppression, but I think that it can be dealt with in a way without making it inflammatory. I think there is some truth in the history, that is part of the historical segment, and I would really hope that as we move ahead, we can find common ground.

I mean, I think this is really our effort here throughout these three days, and as we have ahead, is to see if there is a way that we can come together, not to serve us, but it is going to serve the public far better if we can come to a shared perspective.

So, we may need to come back to this at some

later time to understand what each of us means in each of the sides, and then give it back to Tom and Wayne and the group, and ask them to come up with a way of talking about it that makes sense to all of us.

So, that is what I am hoping for rather than a minority perspective.

DR. ORNISH: I am leaning towards something that says we recognize that at times there have been examples of suppression, et cetera, et cetera. We are encouraged that there seems to be a growing movement and commonality of purpose, something that puts it in that kind of perspective, as opposed to the way it currently reads.

MR. CHAPPELL: I would support that as well, Dean.

Joe, and then Joe.

DR. PIZZORNO: I want to be very clear that I agree with the intent that Jim and Dean just stated. We should say this in the least antagonistic way and the most facilitating cooperation and collaboration way that we can, and we cannot leave out the historic reality that CAM practitioners and institutions have had to deal with.

My teachers were taken out in handcuffs in front of their patients for practicing what is now becoming popular. So, this is what happened.

MR. CHAPPELL: I think what I am hearing is that there is a need to structure this historical section in terms of where we have been, where we are now, and then where we are trying to go. Those are the three frames of time that I think might help this moving target, this evolutionary aspect of CAM.

That way, you are able to honor the realities of the historical ugliness of this. That is just documentation, it is not orientation of language or attitude. You can talk then about where we are now, Jim. I think we can do where we have been, where we are, and where we need to go as this kind of evolutionary issue.

That is what is making this whole task so difficult for us all, because we can't get into the same time frame together to have a dialogue, and unless you do break it down that way, we can't reach agreement, and I think that is one way to do it, that there is a historical reality, there is a real flux of where we are now, and there is a real hope of where we need to go on

this.

I am going to encourage that kind of frame to the historical piece. That will allow us to be much more specific about what CAM is and how it relates to the aspirations and orientation of the Commissioners, because we have a world view that has shifted from the historical perspective here.

That is how I am offering up these combinations of suggestions. I am almost out of time, and, Joe, I know wants to say something.

DR. FINS: I want to echo what you said, I completely agree with that historical evolution, but I also want to say that this Ven diagram concept can also be utilized as a political picture, because the more overlap there is, the more consensus there is, and consensus is really what we are after.

So, maybe we need two pictures. We have the Ven diagram from 30 years ago, like this, and we show the convergence, not the complete overlap but that there is an evolution. There wasn't consensus to even have a commission like this 10 or 15 years ago. There is now. There is a political balance.

The bigger that overlap can be, the more attraction this will have politically, because we have all agreed to that overlap.

MR. CHAPPELL: Great. Charlotte.

SISTER KERR: I just wanted to say, and it is congruent with what has been said in your summarizations, but for myself, I would like to speak that the spirit of this chapter for me was that it was to be an invitation to the reader to listen to the story about the evolution of healing in America. This is why these points Dean and Joe, and all, are making, when you talk to someone, you invite them to listen.

You have to, I believe, start with a conceptual framework, the overview that I think that people want to hear, the world view piece that we don't have yet. The history, you don't start off with, which has been acknowledged, the marginalization, that kind of conversation at the beginning.

This is just a point I have, and I don't know what will happen when we get to reading the overview, conceptualization, or the world view part, how congruent are we as a commission, still. My own feeling is when we

get to that, we may have some discussion we didn't expect, and that will affect, of course, this whole chapter.

Thank you.

MR. CHAPPELL: Thank you, Charlotte.

Dr. Gordon.

DR. GORDON: I just wanted to make a procedural point that as we go through the day, it is important that the order that is here is not necessarily the order of the report, and that is still to be determined.

So, in this section, marginalization, just for an example, could be very much fitted into a history section that could be further down in the list. Just because something is at the top now, doesn't mean it stays at the top. That is really up to all of us, and to the workgroups in particular.

MR. CHAPPELL: I want to thank the commissioners for each of your contributions. This is very, very helpful. I think you have given us very good guidance, and I think we can accomplish what I hear many of us asking.

DR. JONAS: Are we ready to talk about

principles? Let's turn to page 6, Guiding Principles of the Commission. These actually are taken directly from those 10 principles that were initially put up on the flip charts that the different groups came up with and then were kind of put together.

There has been an attempt to simplify them. The initial ones, some of them had quite a number of words in them that were overlapping, so this version is an attempt to kind of bring some of those overlapping things together into a single set, and also to put a label on them, which certainly all of this is open to change, but a descriptor that kind of encapsulates what that "principle" is, because if you have an entire paragraph, you have to look at the entire paragraph to say, well, what is this about; what is the meaning about.

So that, the bold terms are really terms to try to help you identify what the core issue is. It may be that we want to make that several words or several phrases, or something like that, without making it too long, so that then one can't get the gist of it.

In some ways, we have been preempted by the Institute of Medicine, because many of the principles,

not all of them, and I think this is an important area for discussion, have been outlined in the 10 principles and core values of the National Academy of Sciences' report on the way to improve health care in the 21st Century. That is on page 8, "Crossing the Quality Chasm."

Does anybody know, has this been published? Is it is officially out and sanctioned, and this type of thing? Because I think before, it was not officially out.

So, here are core 10 beliefs. I have marked the first five as being almost exactly parallel with many of the core principles that we have in ours. Some of the others deal with health system management, which this is largely about, so I think we are really in congruence with some of the mainstream thinking that is going on in terms of what is needed in the health care system.

I like that. I would like to make sure to emphasize that bond, and it may be that the wording of these principles are such that we can make it clearer that we are congruent with those. So, that is one item I think that needs to be discussed.

The second item is, these are not in priority order, and I think it is important that we figure out, is there a priority to these and, if so, what do we want to have up front, and not.

MR. CHAPPELL: Thank you. I actually would like to begin with the opening paragraph of this section. I do think, knowing that this will probably come at the beginning of the document now, that we need to address this shifting paradigm or shifting world view from preoccupation with illness to one that is concerned with both illness and wellness and that CAM is very much the promotor of health.

I would like to see this paragraph identify the part that we play in helping to promote this shift in world view or paradigm from a focus on illness to a focus on illness and wellness.

It doesn't occur anywhere, yet we speak about it all the time in these meetings, and this would be in the introductory paragraph of whether we call them guiding principles or whatever, this really helps set up that shift.

We can do that apolitically and very positively

by referring to a shifting paradigm of health orientation.

Go ahead.

DR. JONAS: Yes, I agree with that. In many ways I think the summary definition, which I personally think ought to be up front, I think when you are starting something, you ought to have at least some kind of definition up front and then go to the guiding principles, but they all should be crammed in as close to the front as you can.

Actually, I think we have some wording in there about the world view of shifting more towards wellness and health promotion, so I like that. I think maybe we should make sure that is in the principles.

Joe, and then Linnea.

DR. FINS: I just want to say, though, that there really are parallel tracks here and I wish Dean were here, but the Framingham study and cholesterol management and Healthy People 2000 and 2010, the United States Public Health Service and the great work that they do, we are doing a lot of the same things in parallel, so again, to overcome the dichotomous world view.

One vector ended up being coronary bypass grafts, another vector was Dean Ornish's work. They both have similar origins and different vehicles to achieve promotion of cardiovascular health. So, I think that that is one thing.

The other point, if I could put a hierarchical thing in first, I think the partnership is probably something we want to maybe highlight in a rank order as being so important, because partnership enables all the other things.

DR. JONAS: Let's not get into prioritization yet because that is an area that I think we should discuss. Just other general comments about the principles, and then I think we actually have time to go through the principles and then say, all right, then, which ones do you want first and are there some wording changes that you would like, unlike the wordsmithing of the definitions, I would like to see some wordsmithings on these preparations.

Does that sound like a reasonable approach, should we do that? Yes.

MS. LARSON: This is to the comment of the

similarity between some of the principles and the core beliefs, core beliefs of Crossing the Quality Chasm. We might want to actually highlight that and be saying this is noteworthy that two independent bodies came up with very similar core principles, beliefs, and then to actually detail how they are.

You made a statement, Wayne, the first five, so then we write here is the correspondence, and I think it is important to say these are two independent bodies that came up with these at similar times, but with no overlap.

DR. JONAS: So, make the link more clear.

MS. LARSON: Make the link more clear. Also, I have a technical question. I have no idea about what "safety is a system of property" means.

DR. JONAS: Actually, that relates I think directly to complementary issues because, in general, many CAM practices are inherently more safe than more aggressive types of approaches, so it is a system, it is a property of the system of many CAM practices, I think if you were make an analogy of that or make an example of that.

I think CAM is an example of systems in which

safety is more inherent than some other types of more aggressive practices, but I am not sure if that is what they meant.

Shall we go through the principles? I think we should do that, again realizing that the initial phrase, we might want to make it clearer like instead of just saying "evidence," saying "the importance of evidence," or a small phrase to kind of capture that.

DR. GORDON: Wayne, that is fine. If there are other issues, though, that you want to cover here, or anyone else wants to cover, we need to leave some time for those, as well, in your section.

DR. JONAS: Well, there was nothing on my section, but there may be some other things earlier than this that people want to talk about.

DR. GORDON: If you want to spend some time on these and then leave at least 10 minutes at the end, and maybe Michele can give you a signal, and if there are other issues that people have, they can raise those issues and we can talk about them before we come to see where we are at the end.

DR. JONAS: Who is going to signal me?

MS. CHANG: The problem is when you have approximately 12 minutes for just the guiding principles, and then you have got five minutes each for mission statement and historical context. So, how you want to manage that is up to you.

DR. JONAS: Jim, are you referring to other issues besides those?

DR. GORDON: If there are any other issues besides the ones you have listed here.

DR. JONAS: How much time do I have for the guiding principles?

MS. CHANG: You have about 12 minutes left.

DR. JONAS: When I have 10 minutes left, let me know, and we will go to other issues.

MR. SWYERS: Since we have already dealt with historical context, we could probably go into that at that time.

DR. JONAS: Let me make a suggestion. Rather than now going through and wordsmithing each one, which I think maybe would be a secondary thing, I think we should talk about priorities and links, so how about if I open that up. I think Joe had already mentioned that, one,

partnerships was important.

Is there a particular order, are there particular principles that you think should go up front?

DR. FINS: Crossing the Quality Chasm in the earlier IOM report about quality and safety was about systems, so there may be a segue there between systems of care and partnerships. You can't have a system without partnerships and dialogue and communication, so that might be an umbrella under which everything else follows just logically.

DR. GORDON: The issue that seems important to me is that it be very focused on people, on individual people and on sort of the community of people rather than from a professional perspective.

I think if we focus on issues like wholeness at the beginning, and if when it comes to partnership, part of that partnership is also the partnership between ordinary people, whom we call patients, and people who are professionals.

For me, that is the strongest feeling that needs to be there. I am not deprecating any of the other pieces, but I feel that that is our up front

representation that needs to be in that area.

DR. JONAS: We have got two votes for partnerships, one for wholeness.

MS. SCOTT: I do support what Jim is saying. For me, I think the bolded words are not resonating with me. Wholeness was one word I had down, safety, wellness, equity, and it may be embodied in all of this, so I would just like to keep open the idea that we would not necessarily stick with these bolded words, because they don't bring that wholeness, people perspective.

DR. JONAS: Right. So, taking the bolded phrases and making them more phrases similar to in the IOM report, which gives a little bit more meaning to it without doing a whole paragraph.

MS. SCOTT: Right now that is what I am feeling.

SISTER KERR: I would just like to point out, and I have brought this up many times over the last months, and as a group, I would like us to decide what we would like to do.

Under Health and Healing, we often have statements throughout the report that we have been

working on, interim included, when it started, you see the line that says, "The body has remarkable capacity," do we want to, as a group, state things like the body-mind has a remarkable capacity for healing? Do we believe that as a group?

We say, when we start with wholeness, as Jim is pointing out is a good place to start, we talk about body-mind-spirit, environment da-da-da, but I think today, we should decide, so that when we read the report, all the time we are consistent. Do we want to say body-mind-spirit, do we want to say body-mind, and assume that includes spirit, and do we not want to do it?

Thank you. So, what do we want to do?

DR. JONAS: Well, I know what you want to do. I agree, I think we should put in body-mind-spirit actually.

Joe.

DR. PIZZORNO: I would like to second what Jim suggested, as well as what Charlotte suggested. I like the idea of the first principles being those which emphasize the philosophy of healing and wholeness. Charlotte, thank you very much for the body-mind-spirit

language. I think that is wonderful. We should use that consistently.

DR. JONAS: So, is that a vote for health and healing being somewhere towards the front?

DR. PIZZORNO: Absolutely, wholeness, health, and healing right there at the front. That is what this is about. A little bit of wordsmithing on the principles, after "Practitioners," I would add to words, "disciplines, institutions."

DR. JONAS: Where are we?

DR. PIZZORNO: Under "Partnerships," right after "Practitioners, complementary practitioners," add "disciplines, institutions."

DR. JONAS: "Disciplines, institutions." Okay.

DR. PIZZORNO: It would just be more comprehensive in how we are stating this.

DR. JONAS: Okay. Other comments?

DR. FINS: I worry about it getting a little too fuzzy and a little too -- I mean I agree with it in principle as something that informs my own work as a physician, but I think that it can be misunderstood, it can antagonize people. Secular science might be

antagonized by notions of spirit in this context.

So, I think we need to be very careful. Maybe Dean can help me here, but I think it is his red flag land mine comment.

DR. ORNISH: I wasn't called on.

DR. JONAS: You are called on.

DR. ORNISH: Thank you. I think all of us certainly agree with the idea. Maybe if we could have somewhere in here, just like you defined earlier on that CAM -- there is some footnote here -- basically, you are saying, like on page 6, complementary and alternative and integrative are kind of synonymous. Maybe we could say somewhere that when we say "body," as a general principle, we are talking about the larger issues that encompass the psychosocial, the emotional, and spiritual dimensions.

I personally think that language sounds better than body-mind-spirit, and that when we talk about the body, you know, throughout the document, we are not limiting it to that, but that every time you say it, just like you don't say he or she, even though you might say when we say he, we really mean all genders. It just

becomes clumsy and awkward to have to actually say that every time you mention the word "body."

MR. SWYERS: So, you are suggesting a footnote.

DR. ORNISH: Well, just something that says, early on, that as one of the overall principles, that we are talking about incorporating the psychosocial, the emotional, the spiritual dimensions, and that later in the document, when we make reference to the term "body," it is really in that larger context. And leave it at that. I don't think you have to say it every time.

SISTER KERR: I think I would understand what is being said. I think "body-mind" has become more the generic term that includes the body-mind-spirit environment. If you are going to footnote something, I mean, this could get deep here in terms of issues of he/she, et cetera, and gender.

I think maybe I would eliminate it all and put "spirit" if I wanted to make a point, but since I am trying not to be too radical here, I think the body-mind footnote is a common use.

DR. FINS: Another possibility is to give it the importance that it is due and put it in the

historical section as a major element of what has motivated CAM in contrast to the secular, scientific, allopathic approach. We don't want to give it short shrift, but we also don't want it to be pervasively antagonistic that people would find it offensive.

DR. JONAS: I think that is an excellent point.

MS. CHANG: Wayne, you have about 10 minutes.

DR. LOW DOG: I thought if we put something like wholeness at the beginning, I also am in favor of that, and it says, "Health involves all aspects of life, mind, body, spirit, relationships, environment," and if that is our opening statement, I think that is a powerful one to begin with, and I agree, too, that if you start reading mind, body, spirit throughout, that it also loses its power when it is used like that, but I think that that is an important one to open with, because I think it truly does reflect healing on all kinds of levels.

DR. JONAS: So, another vote for wholeness being up front, right, and healing, I think also partnerships, and I think relationships is a word that is not too up front out here, but is inherent, and we maybe want to make it more up front is another thing that I

heard. It is up front in the IOM report.

MR. CHAPPELL: I do think we need to, as we order the priorities here, these priorities need to come from the true perspective of where we are as a CAM community, and not trying to tailor a document for a particular reader.

This is the most powerful presentation we can make in this section as a group of commissioners because this is saying what we believe, what are the core values, and I look at something like evidence, and I agree that that needs to be certainly in the first half of the group, but I don't think that it needs to be first just because we are trying to speak to an audience that is trying to dismiss us.

Therefore, I think we need to be true to ourselves on this, be strategic in the way we use some of these other principles like evidence, but I don't want to see us dilute our power. So, I am agreeing with the idea of wholeness and health and healing, partnerships, prevention. I mean, my goodness, that is what we are about.

DR. JONAS: Comments on evidence?

DR. WARREN: Well, I am looking at what does a holistic practice really entail, and your guiding principles is part of every bit of it. What is utmost in this whole thing is health and healing and wholeness for the patient. Those are the first two.

I like wholeness first because it defines life, it defines mind, it defines body, and it helps define what health and healing is. So, I would say wholeness one, health and healing No. 2. No. 3 is every single person that walks into our office is an individual. I think No. 3 ought to be an individual.

No. 4, every individual has choices. No. 5, every individual is educated and needs empowerment. No. 6, I think prevention. No. 7, the public involvement in the prevention through education and empowerment. No. 8, dissemination of that information.

No. 9, then, you get to evidence, and No. 10, you get to the partnerships.

DR. JONAS: I am going to take two very short comments, and that's it.

Joe.

DR. FINS: I think there is a confusion here

between principles and process. Health and healing, wholeness, individuality, I think are principles. Process is evidence, dissemination, partnership, in other words, so we are talking about two different categories of things here.

MR. CHAPPELL: No, we are not. No, we are not. I am just going to intervene here. We are talking about what we deeply believe in as a group of people, and that is why we scripted this group. That is why we put this group, and then we started calling them something else. These are our core values. This is what we believe in.

DR. FINS: Right, we believe in all of this, these are all principle beliefs.

MR. CHAPPELL: Right, we do believe in all of that.

DR. FINS: What I am saying, though, is that, for example, evidence is a way of achieving health, healing, wholeness, and individuality. Using that, but evidence, in and of itself, is a subset of those more transcended principles.

MR. CHAPPELL: I don't agree with that.

DR. JONAS: Tieraona asked one, and then I am

going to ask everybody to do what George just did, but I want you to write it down, and we are going to actually see kind of what we come up with.

Go ahead.

DR. LOW DOG: That is kind of where I was at. I just wanted to, before we do that, I like the first four, but I think evidence then drives a lot of -- to have education, to have dissemination of that education, to have all of that, you have to have some evidence for what you are talking about.

I would have ranked it a little bit higher up, but probably No. 5, and then driving it on the rest. I agree, I think that as a provider of healing, as somebody that works in that field, I think most of us are driven pretty much by seeing our patients as being whole, and their freedom of choice and their individuality, but I would rank evidence higher. I would have put it up around No. 5.

DR. JONAS: One of the things I hear is that it would be nice to kind of link some of these, so that you can see how one follows, and what you mentioned, certainly individuality and the importance of choice, and

this type of thing, that that could probably be done better throughout here after we get kind of our priorities established is to try to link those.

Dean, last comment.

DR. ORNISH: Real quick. I mean, even under "evidence," I think if we could put something in there, instead of just saying that it will enhance the development and delivery of these services and products, something that turn out to be scientifically valid, the way it reads now is like we want to get evidence to do things that we want to do as opposed to looking at evidence to see which things are worth doing, and I think that is a really critical thing that anyone is going to pick up on as a bias of the Commission if we don't change that.

DR. JONAS: I would have some wording issues on that because I do not word that in that statement. I see help to identify, in other words, you use scientific evidence actually to find what is safe and effective. I mean that is how I read that.

DR. ORNISH: Well, apparently other people share this, too, so if you could just put something at

the end, something along the lines that those that turn out to have, those that are scientifically based, those that have evidence to support them as opposed to --

DR. FINS: The phrase "generating evidence" in the sense that you are fabricating evidence.

DR. ORNISH: That is important actually. You are trying to come up with evidence to prove what you think you already know as opposed to trying to search for truth.

DR. JONAS: Okay. So, wording on that, so that it makes it a little bit stronger in terms of -- yes.

DR. GORDON: I think one thing that would be helpful, and I know you want to get specific words, but it may be helpful in this period of time to get some of the principles flushed out, just as we are doing with evidence for all of the different categories, and then the point that you make about linking them, I think seems crucial to everyone.

I think the more we can contribute to expanding and focusing what we mean, just the way Dean and Joe were doing with you, on each of these, the better.

DR. JONAS: How much time do I have?

MS. CHANG: Just a few more minutes before you need to finish up with mission.

DR. FINS: May I make a parliamentary question here? I am just wondering, I think we are reaching consensus on this. I don't know what the utility is of a half-hour for Jim to do what these guys seem to be doing already. If we could maybe get more time for them to finish up.

DR. GORDON: I think on this one we can, because I feel like I have a pretty good order, so I would like to give them 15 more minutes and just take 15 at the end.

DR. FINS: Thank you, Mr. Chairman.

MR. SWYERS: Yes, I think it would be helpful at the end if we can summarize just for my purposes to try to figure out where to go from here.

DR. JONAS: So, we have 15 minutes, we have been reprieved. Breathe.

George.

DR. BERNIER: I would like to cast my vote for the inclusion of evidence as one of the very strong parts of our outcome. It is I think something which is more

and more being looked for and being utilized.

DR. JONAS: Another vote for evidence, and so, as has already been mentioned, a rewording of it to make it clearer that we are really trying to separate the wheat from the chaff, if you will.

Joe.

DR. PIZZORNO: I fully agree with the comments that Dean and George stated, and maybe something along the lines of we perform the research to provide evidence to enhance the development of these healing arts to make them more effective and safe. I think that is both issues, the safety and efficacy.

I don't know how you put in language to say, remove things that don't work, but it would be nice if we have some kind of language like that.

DR. JONAS: I think you can say it.

DR. FINS: I think safety should be one of the bullets, which somehow is not here. We are going to talk a lot about adverse event monitoring and the OIG report, to be consistent, we need to do that.

DR. JONAS: You are proposing another principle?

DR. FINS: I might be, if it is not here.

DR. JONAS: So more emphasis on safety.

DR. FINS: Well, it is a subset of evidence, but evidence means something else, so I don't think I am proposing something that we haven't agreed upon.

MR. CHAPPELL: I think, Joe, what we need to do is move from the single word "evidence" to the phrase "evidence of safety and efficacy."

DR. FINS: Yes, evidence of safety and efficacy.

MR. CHAPPELL: That is where your phrase can be more helpful than the single word.

DR. FINS: The other point which I think might be very helpful, and it gets back to the point that Tom completely disagreed with, but I know we fundamentally agree, is in a paragraph here, we set out those over-reaching points that are embedded in these other principles, again, health, healing, wholeness, and individuality as the core issues.

Then, maybe we just do it alphabetically, in other words, because I think we could really split a lot of hairs, and if we say it is alphabetical, which we

believe they all are very important, because I think that some of us feel very strongly about evidence, others are going to feel very strongly about choice. This might be a way of reaching a Solomonic compromise without spending a lot of time, and then it's all there, we apprise all of these points.

So, I just put that out as a possible hedge to compromise.

DR. JONAS: Thank you.

Jim.

DR. GORDON: I think that is one way to do it, but I kind of like the idea of trying to pull it together in a coherent way, so that each of these 10 flow into each other. I understand the notion of compromise, but I think it becomes a much stronger statement if it is done narratively that way.

DR. JONAS: Ming.

DR. TIAN: I have a suggestion. I think a good idea was using efficacy and safety for the first one. I still prefer we put that the first, because I believe that CAM is a medicine. If it is a medicine, you have to answer the first question, efficacy and the safety.

The other principles are important, but again, if there is no efficacy, there is no safety, you are not talking about a medicine. I think all the 10 principles are very important, but I prefer this will be the first.

Thank you.

DR. LOW DOG: I just think that evidence needs to rank high up there. I just think that healing is something much more than that. I think that healing, I mean the "who," I think did a good job, sort of it is the active integration of our minds, bodies, spirits, and social beings, and that that is really what healing is all about.

That, I think is true whether you are talking mainstream or CAM. So, I think some statement about who we are, the essential essence of who we are, about holism, I think is very important.

I don't think evidence should be down at the bottom of the list, because I think it then informs how you are going to do education and prevention, and I think all of those things without evidence, you don't know what you are doing, so I think it needs to be up there, but I am still high on the list for sort of the healing

overarching principle.

The IOM, I think they talked about sort of healing relationships and patients, so even they, they had evidence as No. 5.

DR. JONAS: Their fifth bullet was evidence. You want it higher than that?

DR. LOW DOG: I want it higher.

DR. JONAS: You mentioned one thing, Tieraona, that I wonder if it is a general consensus, is that we at least conceptually in the text somewhere link to the WHO definition of health.

DR. FINS: That has been widely criticized as being way too expansive. It has been criticized as being overly inclusive and saying that health has gotten to other human sectors, and it is no longer health care, it is something else.

DR. ORNISH: I just want to say I really like Tom's suggestion about expanding the word "evidence" to "evidence of safety and efficacy." I do think that should be first for a lot of reasons. It really brings people together.

It is not distorting what we say to please

another reader, but it is also mindful of the fact that this is something that really brings everybody together, and then it marginalizes opposition, because if you say we are in favor of evidence of safety and efficacy, then, what do people say, oh no, we want things that aren't safe and effective?

You know what I am saying, it really seizes to the high ground and the middle ground all at the same time, so I like your suggestion.

DR. JONAS: Strategically, politically, and strategically correct, yes, not just correct, but valuable for integration purposes.

DR. CHOW: I have always liked the broad statement of the World Health Organization, and if we delineate that further with our own definitions, I think it would be a nice combination.

I think the four, wholeness, health and healing, individuality, and choice can be put in a nice paragraph, and then evidence comes right after that, before the others, and the others, it is okay.

DR. JONAS: So, put them in.

DR. CHOW: Yes.

MS. SCOTT: I feel very strongly that wholeness needs to be first. I would recommend we really could fold in wholeness, health, and healing as one, and then I could support evidence being No. 2, evidence for safety and efficacy being No. 2, and then the rest following, individuality, choice, because I think they are both important.

I originally had evidence as No. 5, but based on the discussion, I could see moving it up to a No. 2, but I really think the essence of CAM is really between wholeness, health, and healing.

DR. JONAS: Health and healing, right. Okay.

DR. LOW DOG: I like Julia's suggestion, and I think combining wholeness, health, and healing, I think makes sense, that that could be just as if we were doing evidence, safety, and efficacy, I mean that we have sort of made the phrase, I think that that goes.

I think that also, it is recognizing all of those aspects that drives evidence. You know, evidence doesn't exist on its own. You have to have it within some sort of context, and it is partly through defining wholeness and the body's ability to heal that will drive

some of the new research that is going to be done.

So, I still think that wholeness, health, and healing, and I think again, it could be 1, make it 1, and then, No. 2, your evidence, safety, and efficacy, No. 2, which is right beneath it. So, I would support Julia's.

DR. JONAS: I think they are both very important. I would be careful not to make them one. I think they are different. I think healing processes, the stimulation of healing process is one concept, and the idea of then everything being connected and the importance of paying attention to that is another concept, but I wouldn't merge them.

MR. CHAPPELL: Yes, Wayne, I support your comment there. I do think they are different enough to be treated separately, to combine them will dilute the opportunity, so the order of priority, I think is great, but I would like to see them kept separate.

DR. JONAS: Joe has the last word, and then I am going to summarize.

DR. FINS: Maybe as a compromise, because there is the evidence crowd that will not be happy, maybe if the opening paragraph, Julie, maybe if you could live

with this, the opening paragraph stresses wholeness, health, and healing, and then the first bullet is the evidence, efficacy, and safety, and then the second bullet would be health, healing, and wholeness, if we broke that up, in other words, so it is in the opening paragraph as an important over-reaching principle.

Then, we get the evidence, efficacy, and safety, and then health, healing, and wholeness as 2 and 3, so we have kind of created an evidence sandwich.

DR. LOW DOG: I just wanted to ask Joe something. Joe, I am just in full support of evidence, but I am confused where we are blocking on this wholeness as being the first. Is it the word "wholeness," because this is a principle that guides us in mainstream medicine, this is what we all believe.

We didn't become physicians to study evidence. I mean we believed in humans and their wholeness, and we wanted to participate in that process, and evidence supports the art of medicine.

We are artists basically that use evidence to support what we do, but it seems like the fundamental foundation of all medicine, all healing all around the

world is this belief, and I am not sure if wholeness should be it, or health.

Maybe it is the word "wholeness" that is a trigger or something, I am not sure, but I think we could come up with some phrase. I think evidence then supports that, but that is the core value. I am just wondering where we are at with that.

DR. FINS: I guess the issue, if we define wholeness as mind, body, and spirit, we don't have evidence for faith, so there is a tension. So, it is a language issue. Again, I don't want to be overly defensive, but I think we have to write a defensive document.

DR. ORNISH: A mindful document. Again, I think if you can bring people in at the beginning, around something that everybody agrees on, it just makes everything flow easier. It is not a rank order of values, of importance, it is the best strategy of bringing people in, that's all.

DR. JONAS: I have Charlotte over here and then I want to just make a couple summary comments, because I think -- are we getting towards the end?

MS. CHANG: You have five minutes for summary and five minutes for a mission statement.

SISTER KERR: I would like to give Tieraona an award for her statement, please, and then I would like to say, when we look at the National Academy Institute, the 10 principles, they have healing relationships as No. 1, and patients' needs and values.

So, when we get into, we call it sort of individuality and partnerships, I am not so sure our partnership paragraph emphasizes health coach and patient, or practitioner and patient enough, but I think we have got to get back here to sort of the art form and what we are all about in relationship.

Thank you.

DR. JONAS: Okay. We have heard a lot of comments, I am sure we will hear more, and welcome to accept any suggestions on wording, principles, et cetera. What I have heard is that we need to do some changing of the phraseology especially the areas in bold, for example, in order to get it clearer about what we want, in some cases, maybe mixing some of the areas, so that we get the principles out.

We have had a number of suggestions, I would welcome some suggestions from you, and I am going to ask you to do that in just a minute. The importance of wholeness and healing are clearly there. The importance of evidence, safety and efficacy is clearly there.

The emphasis on relationships and the development of relationships is not so clearly here and needs to be brought out.

I think linking in perhaps a more specific way to some of these IOM issues, as well as to some of the others like Healthy People 2000, perhaps the World Health Organization, et cetera, would be something we would also look at, making clear that we are talking about mind-body-spirit, perhaps not in every single phrase, but in one of the up front statements or at least in one of the guiding principles.

What I would like to ask you to do now is I would like you all to take a piece of paper, and I want to spend five minutes, and I want you to rank order on that piece of paper, 1 to 10, the principles, and I would like next to the principles, I would like you to put if you have any wording changes to the bolded areas.

Remember, we have to keep that pretty short, notice the IOM is a phrase, not even a sentence, and that you rank order your principles from 1 to 10 with any kind of changes in the phraseology of the bold statement in that, and, Michele, if you could collect those, we will take those.

[Pause.]

DR. JONAS: Tom recommended doing the top five. Is that reasonable? Okay. So, just do five, that is a minute each. I am trying to get both the order and also some phrase changes that you might want to have in that, and we will take a look at those and try to put those together for revision of this.

[Pause.]

DR. GORDON: Wayne, Steve has reminded me that the audience has not seen the 10 principles. Do you want to read them out loud, the way they are written down here?

DR. GROFT: Just the bold parts.

DR. JONAS: Just the bold parts?

DR. GORDON: Yes.

DR. JONAS: I will try to paraphrase them a bit

perhaps.

The first one is on evidence, that is, commitment to using science and evidence-based medicine for identifying safe and active, effective practices.

The second one is dissemination of quality information, promoting efforts to thoroughly examine the current evidence and make information about that available in a timely fashion.

The third one is prevention, emphasizing the importance of the promotion of health in addition to the treatment of disease and its prevention.

The fourth or the next one is health and healing, emphasizing the marked ability of individuals to heal and recover, and to support that. Wholeness, that health involves all aspects of life, mind, body, spirit, relationships, and environment.

Individuality, recognition that the person is unique and has a right to have their health care customized to that uniqueness. Choice, the freedom, individuals should have the ability to choose freely among the safe and effective therapies that are available.

The next is education and empowerment, especially emphasis on educating individuals continuously about prevention, healthy lifestyles, and empowering them to self-care.

The next is public involvement, recognizing the public and consumer as being the main driving factor in this and that they become more integrally involved in setting prioritizations and decisions.

The last one was partnerships, emphasizing that good health requires collaborative teamwork between conventional practitioners, research, and also between health care practitioner, patients, and among patients, both in research and in --.

MS. CHANG: I am going to come around and get these now. Wayne, do you want people's names on these or do you care?

DR. JONAS: It is up to you. Optional.

MS. CHANG: We are out of time, unless the chair cedes you some of his time.

DR. JONAS: Well, the historical context, I don't think we need to talk about. I guess I would just like, I mean the plan is to do a mission statement, so

perhaps just a general comment on is that something that people would like to see and would like to see us try to come up with a mission statement.

DR. GORDON: Wayne, do you want to say what you mean, a little bit more, by "a mission statement"?

DR. JONAS: Tom? He is much better at that than I am.

MR. CHAPPELL: I am wondering whether the mission statement was a thought that came out of the core values, what we believe work. I am trying to remember the origin of the mission statement.

Basically, if we have got a set of core beliefs which we are calling guiding principles, that is sort of the philosophical orientation, and then the mission statement is more what are we going to do about it. It is the here what we are about.

I am not sure a mission statement is actually relevant for us, so I want to raise my doubt about the need for it, but I don't want to preempt Wayne's idea about this, or Jim's. I have forgotten where this came from.

DR. JONAS: I do too, actually. Linnea.

MS. LARSON: We actually had a mission, and it was given by the Executive Order. I think that highlighting the Executive Order, and this is how we have organized our understanding under the guiding principles is useful.

DR. JONAS: That was actually my sense, too, is that this was sort of a reiteration of what our charge was, and that is our mission, is to try to meet that charge, so that comes out of the Executive Order. I didn't know if we wanted to rephrase that or emphasize that. I mean, it is going to be right up front in the actual report.

MS. LARSON: I really do believe that we need to emphasize and quote directly what that Executive Order is and then make it very clear about how we have shaped what we are doing, and that would be our mission.

MR. CHAPPELL: That is very helpful, Linnea, and I think it is probably worth the task. Let's try it. It is the action orientation of the Commissioners' work, whereas, the guiding principles are more the belief orientation, one's belief, one's action.

Why don't we give it a try. I am willing to

have our committee give this a try, unless you already have done it.

DR. JONAS: A mission statement?

MR. CHAPPELL: Yes.

DR. JONAS: No.

What I heard is that maybe we don't need one actually, as long as the charge, what we have been tasked with is up front.

DR. GORDON: It is time now. We have 15 minutes, in which I am going to give back, feed back, my understanding of what we have agreed on, and what we perhaps haven't agreed on, and get your response as to whether this is an accurate reflection of what everybody has heard.

Let me say that this section is different from all the ones that will follow, because we are not talking about recommendations here, we are talking about the structure of the section itself, so we are at a different stage with this particular section. So, I feel comfortable, and hopefully it will work, taking less time.

When we come up with a lot of recommendations,

there may be much more discussion that will go on. I will say where we are, and people will then have a lot of different thoughts about whether or not we really are there and what we should do with the recommendations.

So, let me go through this as quickly as I can, and as I go through this, I want to find out if this is accurate as I go through each one. So, if you could all make some kind of motion to indicate that it is or it is not.

First of all, when it comes to definition, and, please, especially, Wayne, you and Tom, if your understanding is different, please feel free to jump in.

The definition on page 6 is the one that everyone felt much more comfortable with rather than the definition that the document opened with, is that correct?

This may seem kind of dopey to go through each one so carefully, but I really want to make sure because these are the instructions that we are giving back to each of the groups as they do the presentations. So, that is number one, okay, everybody? Yes. Good.

The second is that the emphasis is on the kind

of goals and the aspiration rather than on conflict in presenting the whole field, is that correct, is the feeling tone? Okay.

Third, that there is a sense of some of the issues related to history and related to some of the conflict will be dealt with in the context of presenting where we have been, where we are, and where we are going. Correct? Okay.

Fourth, there is an importance placed on emphasizing areas of overlap and that diagrams may be useful in presenting some of this information. Okay.

One of the other issues that was raised here, that seemed important, is that there be an emphasis on the fact that people are actually using these approaches and that there was a feeling, a number of people felt that that wasn't as strongly emphasized in the section on definition and on where we are right now.

Beyond that, Joe raised one example, and I think other people have in the past raised other examples that it may be useful both here and elsewhere to present a number of examples. It may have to do with hospice, it may have to do with school wellness, it may have to do

with treatment of chronic illness, to illustrate some of these points. Okay? All right.

That is what I have on definition, and as I said, integration and spectrum be both emphasized, that there is an integration of some approaches and that there is a spectrum and some approaches are not integrated, but that they are part of the whole CAM world.

Generally speaking, what I heard, and this I really want to make sure we are correct on, is that we would begin with definition and then move into guiding principles. Is that correct? Tom, no, you are not in agreement?

MR. CHAPPELL: No, I am not in agreement with that.

DR. GORDON: Okay. So, let's check and see where we are with that, because is there general agreement on that? If there is not general agreement, and if there is significant disagreement, then, we need to bring it back to refer the order of presentation back to the subgroup, so I would like to get some feedback about that now, definition first or principles first, or are we not clear yet.

Tom.

MR. CHAPPELL: For me, the first piece of business to do in a communication piece is to address the shift in world view, and it is basically the orientation question.

We have said this time and again throughout the material that we need to have a special section on this. We have come this far with it. It needs to be presented early on, and then we move into the definition of CAM, and then into the history.

DR. GORDON: I am going to move this part of this discussion along very fast. I want to hear other opinions about that, so we can make a disposition of this order of order.

Dean.

DR. ORNISH: Well, I would vote for putting definitions first, not as a relative value, but just to orient the reader, particularly since I would say that the majority of people reading this may be people in the media and politics, or whoever, who don't have much familiarity.

I remember in medical school when we get