everybody's feedback. This is obviously a very complicated area.

Thank you, Wayne and Dean and Gerri, for wrestling with it and bringing it into the ring with you.

[Applause.]

DR. GORDON: Let's go through the draft, take a look at the draft recommendation.

No. 19. There was definitely agreement with that recommendation, and there was a sense that that is going to dovetail with whatever we come up with in a recommendation about CAM Central.

No. 20. We eliminated trained and licensed and spoke about appropriately qualified CAM and conventional professionals, but we also suggested that the committee might take this one back and take a look at it, address some of the issues that were raised, and just come back with it again.

No. 21. There is a whole issue of cost-benefits that relates to recommendations about research funding that we are going to be addressing when we talk about both coverage and also access and delivery. So, we are going to have to review all of this in the light of

what we come up with there.

It becomes clear that we need a separate discussion of budget recommendations. It is not clear when we are going to have that discussion. I think we need to wait and see what comes up from access and delivery and reimbursement, and then we can figure out whether we can begin that on Saturday morning or whether we have go defer that until December.

When it comes to research, there is an issue, I don't remember who raised it, I think perhaps it was Joe, about interactions and indications and contraindications that come up when we are looking at funding of research. That is an area that we want to pay attention to.

Under 21(A),(B), (C), and (D), there was general agreement. I think there is a sense as we go through all these 21's, that we want a simpler reordering, not so much that we want to change the recommendations, but we want all the 21's to be together, and 22's to be together.

Wayne, the system that you began to put up on the board may be the proper way to order it, but we need a simpler, clearer way of ordering these different

categories of recommendations.

The other issue that we need to talk about is the protection of researchers. Did we put that up as a new issue, Ken, for Saturday morning, the guidelines for protection of researchers?

Gerri?

MS. POLLEN: Well, it is not really a new issue. It is one in which we are waiting --

DR. GORDON: It is in the background, but we need a recommendation about it is what I am saying.

MS. POLLEN: A draft recommendation now.

DR. GORDON: Let's see if we can do it on Saturday morning. If we can't, we will give it back. We may well just give it back to the committee and ask them to come up with a recommendation.

MS. CHANG: Or you can just put a placeholder, which is what we did in access and delivery. We put two placeholders in for that issue.

DR. GORDON: Okay. So, we are going to be coming back to it.

Nos. 22 and 23. Again, it looks to me like these may well be combined. We feel fine about those

recommendations. With 22(C), as well as with 21(L), there was a feeling that we are asking our committee to make some recommendations there for us, tell us what we need to do.

No. 23. There was general agreement about public participation, and there is a consensus about that.

On 21(E), (F), and (G), there was a consensus and agreement with those recommendations, and I don't know if I got this right, on 21(G), I think there was a rewording, "Continue to support career development awards to enable both CAM and conventional investigators." I think that was added there, and otherwise, those went ahead as stated.

We are asking for some more specificity on 21(H), (I), (J), and (K), I believe, and I want to make sure this is where we are, we are asking the committee to take these as far as you can take them, and where you can't take them further, that is, in terms of making specific recommendations, put together a package of those issues that we don't have enough information about.

DR. FINS: On that particular cluster of

issues, maybe a representative of your committee and Tieraona can perhaps --

MS. POLLEN: She is on that committee.

DR. FINS: Okay. Then, maybe just let Tieraona do it. That would work. But I think, again, the linkage to the regulation piece has got to be, I think, fleshed out and coordinated.

DR. GORDON: On No. 24, we deleted it. We deleted it because it is redundant of an earlier one.

No. 25, we agree on the general principles, and we are just asking for a reshaping of those recommendations, that is, with an understanding that that fits very closely, that the piece of developing systematic reviews is basically a research piece and that that research piece has a public information aspect, a kind of professional information aspect, and it also dovetails with David's work, David and his committee's work, on providing information to the public.

As we smooth out the Final Report, I think we can indicate here that we need to make these available to the public, and then David and his committee will be providing some of the specific mechanisms for making it

available.

Tom.

MR. CHAPPELL: I would like to ask you whether our recommendations should make an attempt to identify the operating idea to implement the recommendation or just to have the content of the recommendation itself.

DR. GORDON: I will give you my opinion, but I think that is a matter for discussion among all of us. My idea is the more we can get down to exactly how it is going to be implemented, where that is appropriate, let's do it, and where we can't do it, then, let's not do it. That is just my thought about it.

MR. CHAPPELL: Well, that is helpful because I think we could push some of these to more clarity or more creative thinking about that operating implementation strategy.

DR. GORDON: Steve.

DR. GROFT: Some of these recommendations where we want to direct to specific agencies or organizations, we should do so, and we can highlight that in the report, as well as the executive summary and list of recommendations later that will go out. So, we can do

that.

MR. CHAPPELL: But sometimes it is not as simple as directing it to an existing agency, it is creating either the public/private group or --

DR. GROFT: Right. I think that perhaps if we can identify who you would want to do that or put it in terms of -- I think once we get through on Saturday morning, I think we will have an idea of where some of these things may be able to rest.

DR. GORDON: One of the advantages, too, of doing that is that that will help us advance our discussions, if it becomes clear that such and such belongs with the FDA or with NCCAM or any of the other agencies, we can move ahead discussions with them about how to implement it in these next few months.

So, where appropriate, it will be helpful.

DR. JONAS: Good summary, Jim.

DR. GORDON: Thank you, Wayne. Okay.

[Applause.]

DR. GORDON: Do we have a break for 15 minutes?

MS. CHANG: We have a break for 15 minutes. Everyone back by 3:45 for Education and Training.

[Recess.]

MS. CHANG: Session IV, Education and Training of Health Care Practitioners. Our facilitators are Drs. George Bernier and Joseph Pizzorno. Our staff lead is Dr. Joseph Kaczmarczyk.

If all the Commissioners could take their seats, please, and we will begin.

Session IV: Education and Training of Health Care Practitioners

DR. BERNIER: Good afternoon. I take it this is the last presentation for the day.

MS. CHANG: It is indeed.

DR. BERNIER: I would just like to open the discussion for a brief moment, I wanted to acknowledge on behalf of Joe Pizzorno and myself the work that David Bresler and Joe Fins, Buford Rolin, and Don Warren put into this.

We have seven issues and 12 recommendations, and I think it is fair to say that this is one of the focal points, the education part, as it is going to have its major impact upon the next generation of students, not just students of the CAM persuasion, but I think many

traditional students, as well.

DR. PIZZORNO: The way we are going to do this, is I am going to give a quick overview of the challenges facing this committee. George will fill in my blunders and omissions. Then, we will give a chance for the committee members themselves to have a few words, and then we will get into each of the recommendations.

I think in may ways, while there was a lot of work done on this committee, it was in many ways one of the easier ones to do, and that is because if you look around this table, you will see a lot of people with a lot of education, so I think there is a shared value here that education is something that is important and that it is absolutely critical for the evolution of skills and things like patient safety and clinical outcomes.

We also realized it is important that both CAM and conventional institutions, faculty, students, and practitioners become much more educated about each other, and indeed there are some particular areas where there is specific education in conventional medicine that is necessary for CAM practitioners, and in CAM that is necessary for conventional medicine practitioners.

We also felt that because education is so important, that if we are expecting the CAM practices and professions to advance and become a more effective resource for the public, then, we needed to facilitate the educational systems.

That meant facilitating and funding curriculum development, faculty development, student scholarships, et cetera, and recognizing that quality of education and development of things like critical thinking skills and high quality content require investment.

So, we dealt with several issues, about eight of them: Access to funding and other resources for CAM faculty, curricula and program development; National Educational Standards to Practice CAM; Basic or core conventional health care curriculum for CAM students and practitioners; Traditional Healing Education and Training; Participation of CAM students in scholarship and loan programs; Basic or core CAM curriculum for conventional health care professionals at professional schools, postgraduate, and continuing education levels; and finally, Postgraduate and continuing education for CAM practitioners resembling that available to

conventional health care providers.

George.

DR. BERNIER: Our group had I think a very enjoyable experience in dealing with these issues, and I would like to ask each of the participants, if they feel comfortable about it, sharing with us their thoughts in a matter of 30 seconds or so.

DR. WARREN: Well, there were aspects of this that we agreed on and we didn't agree on. One, I don't know, I read it, but I can't remember it now, I have kind of gone through a brain lapse here, but recommended, I felt like we needed a basic background for every CAM practitioner in the United States.

I mean we are talking physiology, anatomy, biochemistry, pharmacology, and that is for all the CAM practitioners, but then, on the other hand, we also needed some of that same type of education for the conventional practitioners, and to weigh that and to get it into the systems is somewhat mind-boggling.

I think a lot of our recommendations we have here are good. I need somebody else to get me off the hook here.

DR. BERNIER: Buford.

MR. ROLIN: Thank you. I certainly concur with the recommendations and enjoyed working with our committee even though I wasn't always available. I'm sorry about that, but especially in the area of traditional healing, I was on the calls when we discussed that area.

I concur with what we have recommended here, and we will get into that discussion with the exception, and I will wait to comment on it, but I do appreciate the fact that we were all, on the basis of the information that I was able to provide, we came to consensus how to deal with the traditional healers and our recommendation for our workgroup.

But other than that, I think as we review the recommendations that have been made, you will certainly I am sure have some comments relative to, and perhaps some recommendations for some change, but it was a very thoughtful process in the efforts that we put into this.

DR. BERNIER: Thanks, Buford.

Joe Fins.

DR. FINS: Perhaps a little concern. I just

want to say that I agree with most of what is recommended here, but I look forward to a fuller discussion of issues of love and forgiveness and the primary care role that is inferred for some of the naturopathic and other practitioners.

I was more comfortable with some demonstration kind of projects, but I just want to put that forward, and I look forward to a broad discussion with the full commission.

DR. BERNIER: Thank you.

I guess David is not available now. Perhaps we could go on to the issues, and that is a task that Joe and I will be splitting up. Joe.

DR. PIZZORNO: Issue No. 1, access to funding and other resources for CAM faculty, curricula, and program development. We discussed this area quite a bit because we realized that there is an issue of, on the one hand, some forces think we should have a level playing field and explicitly state that, while others feel that might be premature. So, the language we came up with is actually pretty similar to what we came up with at the July meeting, and so we have now two recommendations.

I am going to read those recommendations and ask any Commissioners to comment as they think necessary.

Recommendation No. 26. The Commission recommends that appropriate access to funding and other resources for CAM, faculty, curricula, and program development at accredited institutions and by licensed professions should be made possible by amending Title 7 and 8 of the PHS Act to authorize Health Resources and Service Administration, Bureau of Health Professions, to provide this type of support.

Now, there is actually a slight modification I would make to this, and that is on the second line, after "program development at," just put in there "CAM and conventional accredited institutions," and by license professions, put on "CAM and conventional medicine professions."

That is where we stand with that recommendation, so any comments or recommendations on this recommendation?

DR. LOW DOG: I need an explanation of Titles 7 and 8 of the PHS Act. Since we are asking to amend it, I need to know what it is.

DR. KACZMARCZYK: Those are the portions of the PHS Act that give the authority to the Bureau of Health Professions to give monies to schools, programs. It is their authorizing legislation. It tells them what they can and cannot do, and it is very, very specific right down to the detail of which professions.

DR. WARREN: Don't we intend right there for that amending to be handled if we do have CAM Central, for lack of a better word, that would be coordinated through that office as to what the amendment might entail?

DR. BERNIER: I don't think that that is a given.

DR. WARREN: I know it is not a given, it's a supposition.

DR. BERNIER: You were supposing?

DR. WARREN: I was, just me.

[Laughter.]

DR. WARREN: I told you there is a brain lapse.

DR. BERNIER: Joe.

DR. FINS: I want to say a little more about those Title 7 and 8, and again, I am not an expert on

this, but I think the legislation was conceived really with an instrumental purpose in mind. Money was going to flow to engender services that were necessary for the public health.

This, along with loan guarantees and other kinds of entitlements, are directed to meet man and woman power issues necessary to meet primary health care and other kinds of health care needs.

I am concerned that we are giving a level of credence and credibility to certain kinds of practitioners prematurely, that ultimately, they may get, but they don't have right now, and redirecting what will be scarce resources to populations, to potentially underserved populations and from other medical institutions.

So, I am a little concerned about this. We have had long conversations about this on our phone conferences, but I think that this is a major, one of the most important recommendations we have made all day, and I think it really warrants more careful scrutiny and discussion.

DR. LOW DOG: I don't feel comfortable with the

recommendation, the way it is.

DR. BERNIER: So, how would you modify it?

DR. LOW DOG: Well, I think it comes back to my problem. We defined CAM in this box, and we are saying that basically for CAM faculty, curricula, and program development, and we sort of took out just license now, I mean we moved that because it could be accredited. Some of these are not licensed, they are registered, et cetera. But I mean you could be a certified therapeutic touch practitioner, so are we going to send them out into Northern New Mexico to take care of the community, and then pay all their loans?

I mean what exactly does that mean? As somebody who works in a state that has seven counties that don't have a single health care provider, nurse, or anything else, nobody, I am concerned about the impact of that and how that is really going to benefit the communities in general.

In my understanding, those funds are already being cut back, the monies that are available to send people out, so I think if we are talking about what the public wants here, I think if you asked a community out

in the middle of Northern New Mexico who do you want if you have a choice, I think I know what their answer would be.

So, I think in shrinking resources, and this is my problem, because some CAM professions may be at a place that they are ready to do this, but we are saying CAM like this big, general thing, which you refer back to your box, which is a whole bunch of stuff, that is probably not going to be much benefit to a community.

DR. BERNIER: You say if they don't have a choice, how would you feel if CAM providers were involved, if there were 13 counties in New Mexico that didn't have a health care provider, would you accept that?

DR. LOW DOG: I accept an imagery person to meet the health care needs or a visualization? It is not to say that they wouldn't have something to offer, but then you have to think of the logistics. You have to have a clinic for them to practice in. You have to set up the infrastructure for them to practice in.

I mean it's a whole big thing. I mean we deal with this in New Mexico all the time, as I am sure many

other states do, but it is a big thing to set this whole thing up. I am just not sure. This is a big recommendation, and I think it needs more thought, that's all. I think it's too broad.

DR. BERNIER: How would you make it more narrow?

DR. LOW DOG: Well, if you are going to be specific, you need to specify which CAM practitioners you believe are at a point that could serve that function.

DR. PIZZORNO: Well, it says here "licensed CAM professions."

DR. LOW DOG: Your licensed massage therapist, your licensed hypnotherapist. I think we need to be careful of what the public needs and what the Public Health Service was designed to do. I am not saying that massage is not part of public health, I am not saying that at all. I am saying that these are underserved areas, and that if we start spreading funds and people, we may not give the people what they truly need in those communities.

DR. PIZZORNO: I think it is important to recognize what we are trying to create with this one is

education. This is to support education at accredited CAM institutions, to support faculty and curriculum development. It is not about what you are dealing with, I believe is dealt with later on in another issue.

I mean it may be that we don't have exactly the right language here, we are relying on the recommendation we received for the language, but this is about education.

DR. GORDON: Joe, can you make it clear what you mean when you say it is about education, what are the parameters, what does it include, what does it exclude?

DR. PIZZORNO: The intent is to facilitate curricula, faculty development at accredited CAM institutions, just as we have currently for accredited conventional medicine institutions.

DR. FINS: Joe, it seems to me here that these Acts were really designed to have manpower issues downstream of education. That is really why education and manpower is linked, as Tieraona is suggesting.

It seems to me that what we really need to look at what is the effect of federal funding on education, have pilot grants of the sort that are already beginning

to happen, but this is a sweeping change across the entire manpower spectrum, and I don't think there is evidence to say that dollars spent on this is better spent than on producing more neuropractitioners or more respiratory therapists or more primary care physicians, and especially in underserved areas.

DR. PIZZORNO: I would like to remind people that more members of the public are seeing CAM professionals now than conventional medicine practitioners, and right now all the money is going to conventional medicine only.

It is time that we realize that the public is demanding these services and expects that a portion of the funding we provide to conventional medicine go to also educate and facilitate the evolution of the CAM professions.

Tom?

MR. CHAPPELL: I guess I am seeing the opportunity in this for some really important support for CAM. I remember our hearings in Seattle and remembering clearly the students talking about the difficulty they had in funding their education.

They were working alongside people that were funded because it was conventional medicines, and I just see this recommendation as being essentially and primarily for access to educational funds for students and faculty and program development.

There are going to be instances where some limited use of this will be for some situations that we might wish were otherwise, but this is essentially for a provision and a big gap that desperately needs to be funded.

So, I happen to like the recommendation as it is drafted. If there is any way to differentiate among CAM professionals, I am certainly willing to entertain that, but I don't know of any.

DR. BERNIER: Charlotte.

SISTER KERR: I am a little puzzled, Tieraona, in some of your comments, because of exactly what Joe said, as well as it is just allowing access and the consumer will decide, and we will evolve into by walking into the door of the various practitioners what is wanted. It may well be the chiropractor in a rural area, and the acupuncturist except for the injuries of an

accident would be the best people to be there.

I think those priorities would be set within the system itself, I am sure, as far as what you do with a little bit of money.

DR. LOW DOG: I have no issues around education and funding for education, none, none. They are available for any profession that somebody wants to go into whether it is the healing profession or others. I think that education, there should be adequate resources for anybody to go get the education that they want.

So, I have no issue with that here with that aspect of it. I just need to say that I just cannot live with this continued quotation of an Eisenberg study that really has misled a lot of people. I have sent references on other studies to Steve Groft that have clearly showed that actually visits to CAM practitioners are really running between 6 and 10 percent of the population.

The Eisenberg study included everybody who took a Centrum, everybody who went to church, everybody who went to a prayer group or an Alcoholics Anonymous. That is not the same thing as what we are talking about here

under CAM, because we have not included that under our CAM rubric.

So, I want us to be clear if we are talking about the population, who we really are talking about, 6 to 10 percent. Now, access and delivery, that will sort of broaden.

I just think you are going to have to be clear about, when there are scarce resources, let's imagine that this commission was told you are going to have $500 million, and that is how much you are going to have to spend, prioritize how you are going to spend it.

Then, I think we would be a little more focused on what really needs to happen. I think that demonstration projects are necessary for some of these in communities, and I would be totally supportive of some demonstration projects before we start amending legislation.

DR. BERNIER: Jim.

DR. GORDON: I want to make sure, Tieraona, that we are saying -- No. 26 is narrowly focused on education, has nothing to do with manpower, has nothing to do with National Health Service Corps. Am I right,

Joe, in saying this, both Joes?

If this is just, for example, what has happened with NCCAM now is NCCAM has now made available money for CAM education programs. If this is something similar to that, if we are saying to HRSA through the Bureau of Health Professions let's make it competitive, so that an acupuncture program, as well as a nurse practitioner program, can apply for funds for educating of students, that is one thing.

If we are saying the money should be diverted from X to Y, that is another thing. And if we are talking about manpower or man and woman power in the community, that is a totally different thing.

I just want to assure that you stated clearly again and that everybody here understands what we are talking about in this No. 26 recommendation, and then we can go on to the others.

DR. PIZZORNO: Issue No. 5 deals with scholarship and loan programs, and I think much of what Tieraona is talking about is fitting under that.

DR. LOW DOG: Does that have nothing to do with Title 7?

DR. PIZZORNO: I don't know how all these titles and things work.

DR. FINS: It does. If you look at page 5 --

DR. PIZZORNO: We tried to.

DR. FINS: Recommendation 32 addresses it, so they are inextricably linked, as was said earlier, so the recommendation here is the reauthorization of 7 and 8 should be amended to include enabling legislation making CAM students eligible.

So, these are not isolated concerns, they are inextricably linked.

DR. PIZZORNO: So, let's differentiate between the two. One is support for education. The second is for loan forgiveness and rural practice kinds of things. Those are separate issues.

DR. FINS: That is why 7 and 8 are bad places to put this entitlement.

DR. PIZZORNO: So, you are saying these are the wrong place to put it.

DR. FINS: Because it is related to manpower, woman power, which is then related to access in underserved populations, and people who are vulnerable,

who are in counties where there are no doctors, and we are going to put a massage therapist in and call it health care.

So, what I think we need to do is to find a different place to draw those funds. I mean, I am all in favor of education. Let's have hope scholarships, whatever we want to call them, for this sort of thing, but it shouldn't come out of this silo because I think the problem is that it gets to the issues of the underserved that Tieraona and I were speaking about.

DR. BERNIER: How would you solve this problem?

DR. PIZZORNO: Well, if we were to simply remove by amending Title such and such, et cetera, and leave the rest of it as is, would that work for you? Okay, and we will leave it to the government to decide how to do this.

DR. GROFT: I think what we will do then is get also the exact language in Title 7 and 8, and have the workgroup look at that in its entirety, and then come back with the decision or recommendation at that point.

I think what we would like to do, too, is then pass Title 7 and 8 out to the entire commission so that

everybody can read it also.

DR. FINS: I think if we deleted the second half, I would be much more comfortable with it, and it becomes a pure educational issue, it is not a manpower issue, and then we could argue that these people are going to add value to communities, and it will be integrative versus alternative care.

DR. PIZZORNO: George, that sounds fine with me. Does that sound fine with you, just to limit the last part of that?

DR. BERNIER: Right, and take it back to the group.

SISTER KERR: Would you just clarify, then, what we are eliminating? Just No. 26, the second half? We are temporarily taking that out, and the committee will rethink it?

DR. PIZZORNO: Right, we will look at that and maybe there will be certain sections of that, that are appropriate, or maybe there is another mechanism that is more appropriate. We will take a look at that and figure it out.

SISTER KERR: I just had one other comment, and

I so respect my fellow commissioners, I want to be clear. I had a feeling, Tieraona, and Joe, that there was an assumption that I didn't know was what you might have held, or I want to be sure I heard it, that you actually sound to me like you are assuming that almost all of the time the preference would be for a traditional Western medicine-trained doctor, at least the majority of CAM practices is a priority in the community, is that true, because I have to tell you, I am not sure I am there anymore.

If that is an assumption, then, we just need to clarify that.

DR. LOW DOG: Well, I would say if 90 to 94 percent of people are still utilizing the Western health care system, I think that that is a pretty strong indication that people have not completely abandoned it.

In a lot of our Northern New Mexico communities, we do have massage therapists, and we do have traditional Mexican-American healers. We have herbalists, and we have some Curanderos up in the North, and they do a good job taking care of the community, and there are still huge gaps missing for the chronic

illnesses that are just killing these people.

My biggest fear is that we are going to somehow go down the path of saying, well, we have got a massage therapist in this county, so that we can check off the box that we have got a health care provider and we don't need to keep working to bring somebody else there.

There is no doubt that Western medicine fits in place especially in very isolated rural areas where when emergencies happen, it is very difficult to transport and get people into town. So, it is a place where Western medicine really excels is in very isolated rural areas in underserved populations.

SISTER KERR: I understand, Tieraona, what you are saying, but then when I heard this just now, that there would be cases where Western medicine's need -- it is as if it was an either/or conversation, and I don't think we are saying either/or, because I would agree with you, first-aid-wise, even though epidemiologically speaking, doctors are prepared for the 1 and the 1,000 at a university hospital, and that is not the majority of the needs in the community even though when you are dying and having a coronary, and you need a whatever, you need

acute care.

But I don't think it's an either/or, and I respect what you are saying, and I hear that, I have been there, too, but I don't think we are having to make that decision and this decision that we are eliminating that the community will forsake then looking or valuing or needing the acute care doctor.

DR. FINS: I don't think it should be an either/or, and in conversations that we had at the very, very first meeting related to access, were about the issue of the paradox, providing access to CAM when there was an access to health care, would there be access to supplements and there is not a prescription drug benefit.

So, these things are inextricably linked, and what I think Tieraona and I are saying, and other members maybe are feeling, is that in a situation where you have the single choice, not discounting the value added that the CAM modality or the practitioner has, an immense value in many cases, that you basically want to play a kind of a defensive posture against accidents and sudden illness where there isn't a hospital nearby and you would like to have a primary care practitioner accessible.

It is just a basic safety net kind of issue. I think that by linking it to the Title 7 and 8 here, it ties it to the manpower issue, and that is our concern.

Ideally, CAM practitioners would be value added, it would be integrated, they would be part of a system that was already in place, but tragically, there are parts of this country that does not have access to primary health care.

DR. BERNIER: Tom.

MR. CHAPPELL: I am wondering if we are getting lost in some of the percentages that we have been talking about of how many people are accessing CAM. We have had the information from day one that over $30 billion is being spent by consumers on what they think are CAM solutions.

So, whether they are buying a brand name supplement from a large company is not important. What is important is that they are seeking CAM solutions, and they are spending money for that, and I think we need to just keep in mind that that is what is generating all the activity here is the consumer and the enormous spending power that they are driving behind it.

So, that is pretty persuasive in my mind about how the American public is seeking out these kinds of solutions, and we need to be reminded that we need to serve all those related that are providing that solution to consumers.

DR. BERNIER: I would like to suggest that everybody who is interested in it, look at the Annals of Internal Medicine over the last couple of months in which a lot of discussion and thought by very, very thoughtful people has gone into this very issue, and if we can do that, I think it would help us all.

DR. GORDON: George, I would actually ask Steve and Michele if they could get us copies of those. I agree with you, I think that would be very helpful for all of us to have.

I want to come back to this issue because I think the discussion is very valuable. I would like to focus on what we agree on, and then move on to some of the other areas.

What I am hearing, and I know I am sort of jumping my role right now, but I just want to move on with this, too, is that we do agree that there should be

support for development of CAM curricula for both conventional and CAM practitioners. We don't agree at this time about Title 7 and 8, in fact, there is strong feeling against having Title 7 and 8 here in this.

That is kind of what I am hearing from us right now, and then I think we do need to tackle the other issues related to Title 7 and Title 8 as they come up later on.

I also think if we agree on that, we need to speak in the background, and I know Joe Kaczmarczyk knows this, about some of the efforts that are already moving ahead in terms of CAM education, and what we need here as part of the background piece is what is being done, what isn't being done, what are the limits in education, and we may or may not -- and I sort of give this back to you all as a committee -- want to think about are there scales of recommendations that we want to make or do we just want to make a statement saying that funds should be available, but given the fact that we are taking it out of the Title 7 and Title 8, and we are just looking at it as an entity, do we want to say something more specific about how much education money or how much money should

be made available.

DR. FINS: It would be very helpful, George, maybe as a background piece, I mean I know that the average medical student who graduates from my medical school is $100,000 in debt, it would be interesting to have a sense of the data of the debt burden that various CAM students are engendering, and then have a sense of the scope of the problem, the number of students, the kind of numbers that would be involved just to get a sense of how big a problem this is.

DR. GORDON: I just want to say, Joe, that that actually goes to another question, another recommendation. This one is basically are we going to support the development of programs, are we going to support the development of a CAM program at your nursing school or my acupuncture school or et cetera, et cetera. So, that is more related to loans and scholarships, and the rest of it.

All these issues are so connected, it is hard to tease them out, but I think it is important that we do that.

DR. BERNIER: Thank you, Jim, for your bit of

leadership there, well said.

So, let's move on to 27. The Commission recommends that joint research and educational programs involving CAM practitioners and conventional practitioners should be established and financial support for these programs should be identified.

I would probably put in there "CAM practitioners and institutions and conventional practitioners and institutions," because I think this is more of an institution practitioner rather than practitioner --

DR. GORDON: I don't quite understand the recommendation. One thing I don't understand is why we are having research in here.

DR. PIZZORNO: We probably should cut out the research because that has been said in the research section.

DR. FINS: I think research may be the way that happens in medical schools and Bastyr school, university, have collaborations with the University of Washington through research, so the doing of research is an educational experience, as well.

DR. GORDON: All I am pointing out is that we have to somehow have this dovetail with the research recommendations, where we have already made this recommendation regarding research, we haven't made it as far as education goes.

DR. BERNIER: I think it is a logical step.

DR. GORDON: Yes.

DR. BERNIER: Linnea.

MS. LARSON: My question is a clarification question, and it has to do with these programs should be identified, and the support should be identified, so the job of somebody is to say here is where the money is going to come from. I mean do we need a little bit more flushing out of that?

DR. PIZZORNO: I don't know. I think the staff has to advise us on that. I don't think we have been consistent up until now saying exactly where the money has to come from. So, I don't know if we should be doing that or not.

MS. LARSON: That is my question.

DR. PIZZORNO: I don't know.

MS. LARSON: So, we need some input about that.

DR. GORDON: This is continuing education, is that right?

DR. BERNIER: No, this is primary education.

DR. GORDON: What does it mean then?

DR. BERNIER: It is primary education.

DR. GORDON: Oh, because that is not clear, when you say involving -- this is all primary education for -- how is this different from 26?

DR. PIZZORNO: This is about trying to facilitate collaboration between CAM institutions and conventional institutions in doing education. So, for example, when CAM institutions are trying to develop their conventional basic sciences education, we want them to collaborate with conventional medical schools, and conversely, when conventional medical schools are trying to do CAM education on their campuses for their students, that they collaborate with CAM institutions.

DR. GORDON: I just think that all needs to be spelled out in here.

DR. PIZZORNO: Say it a little better.

DR. GORDON: Because I had no idea where it was taking place from the recommendation.

DR. FINS: I think this lends itself nicely to an RFP for a demonstration project to show mechanisms to foster that kind of collaboration, and sustain that collaboration.

DR. PIZZORNO: Any other commissioners with comments on this one?

DR. GORDON: I think we have said it somewhat better before, I hate to say something like that, but it is like the RFAs that NCCAM has now stipulates if you are going to do a program, you have CAM folks working with conventional folks to develop the program in the institution.

It is a straightforward idea, and I just think it needs to be presented a little more straightforwardly with a little more detail about what it is exactly that we are talking about here.

DR. PIZZORNO: Any other commissioner comments?

Okay, George, I pass the baton to you.

DR. BERNIER: Okay. The next issue deals with National Educational Standards to practice CAM. There is a background here which concludes with, "We recommend that CAM training courses should become more standardized

and be accredited and validated by the appropriate professional bodies. All those who deliver CAM treatments, whether conventional health professionals or CAM professionals, should have received training in that discipline independently accredited by the appropriate regulatory body."

They went on to say, "This would protect the public who use CAM and would improve the transparency of the organization and make understanding what practitioners' qualifications mean in an easier way. It is clear to us that the quality and degree of standardization of training within each therapy are closely linked to how successful each individual therapy has been in overcoming internal division and coming together under the auspices of a single body that agrees core objectives for education and regulation."

The challenges on this are that this would include similarity to licensure and perceived encroachment on states' rights, a degree of complexity, multiple contentious issues, funding requirements, need for legislation and appropriations, questionable authority, and widespread resistance.

The recommendation has been made that the Commission recommend that National Education Standards for CAM modalities, therapies, and practices should be established by professional educational institution organizations linked with the proposed federal CAM coordinating office.

MS. LARSON: I have another technical question. I do not know, and I don't understand what this means. "The challenges include similarity," what is similar to what?

DR. BERNIER: It is similar to having a license, but it is not having a license.

MS. LARSON: You mean standardization is similar to licensure?

DR. BERNIER: I think that what is meant by the statement, it means that there would be similarity to licensure among the individuals who are either getting licensed or were not.

DR. FINS: My sense is that the problem that we are encountering here in having a standard educational approach across the spectrum of practitioners in differing jurisdictions and factions and everything, is

similar to the problem that is encountered I think under the licensure rubric, as well.

DR. BERNIER: Right. It is clearly a very sticky issue. It would be hard for us to mandate or for the government to mandate that individuals go through a process of licensure attainment.

DR. PIZZORNO: George, I have a slightly different perspective what we are saying here. This was not meant to be licensing nor a substitute for licensing. This is rather to recommend that for these various professions, that they have National Educational Standards, so that there is consistency across the country in how education happens in these areas.

Now, licensing and things of that nature are separate, handled by states. This is more like accrediting bodies for various kinds of educational systems, so there is consistency. That is how I was reading this.

DR. FINS: Can I make a suggestion maybe to give this a little more focus as a recommendation, because I think it is a very important problem that George is commenting on.

We so hear in our testimony that different groups have different standards, and they can't agree on like the acupuncturists at how many hours, and I said why don't you guys go to dinner and come back and tell us, and they wouldn't even go to dinner with each other.

So, what I would maybe suggest -- remember that?

DR. BERNIER: Yes.

DR. FINS: I would suggest perhaps that we make a recommendation that the Department of Education might consider a pilot project bringing together an identified group or practitioners in one area, perhaps acupuncture, because it is very evolved, to see if they can have a summit on educational standards as a model program that might be then valuable for other CAM professions or emerging professions, because we really don't know how to bring these people together and have them agree, and they are coming from different backgrounds, different disciplines.

That is a focus, that could be a conference, that could be a facilitative kind of mode for the educational people who are trying to work out standards

and consensus.

DR. BERNIER: If you were to do that, what modality would you begin with? I guess you would have to start with two.

DR. FINS: Since we heard a lot about the issues that related to acupuncture, might bring the leading organizations together and have a summit and see if they could work out what could begin to emerge as a national standard.

Again, it is not a governmental standard, but it is like they have all come together and created a new college of acupuncture or some governing body that everybody would agree to, and see if they could work out a compromise.

I think that would be a very important step for the emergence of the profession, and there may be lessons to be learned from other professions that have gone through this process.

DR. GUTIERREZ: I would like to say that I think we should get more information on the table about states' rights. I found through my experience in lobbying in the State of Washington anyway that the

legislators were not well informed or educated about health issues and just wanted everybody off their backs, and so they would pass legislation based on who had the best lobbyist or the more dollars.

In chiropractic, we have 50 different state laws, and again it is a political issue depending on who has got the political clout at the moment. Down in Texas, chiropractors have been licensed to do manipulation under anesthesia, and there is one college that teaches that.

The chiropractors in Florida want the right to prescribe pain medication, and in a roundabout way to attempt that, they tried to get a chiropractic college at the University of Florida, and they were going to try to change the face of chiropractic across the United States with that university.

We have some states that allow chiropractors to do acupuncture, in Washington they don't. It was determined that breaking the skin is the practice of medicine, so chiropractors can't do that in Washington.

In California, up to a short time ago, they could deliver babies, and because the chiropractors in

California wanted to deliver babies, the chiropractic colleges put that on their curriculum because they knew they would attract the students to their school that wanted to go back to California, and if they didn't change their curriculum, their student enrollment was down.

So, this is very, very complicated, and I don't know, I would like to have some sort of a survey of the states and just see how strongly the states feel about this.

I was on the Washington State Chiropractic Quality Assurance Commission for six years, and up to the time I left, we tested for minimal competency in chiropractic. When I got off, the Commission voted to abrogate the state's rights and let an outside agency with no accreditation or recognition test everybody, and once they passed the national boards, they just came into the State of Washington.

So, I think maybe we are assuming a lot about states' rights and their desire to control health issues, and I would like a much closer look at that.

DR. GORDON: I am struck by the fact that this

seems like a good idea, but in fact, there are so many difficulties. I'm sorry Joe is not here. He raised the example of acupuncture.

If we remember back to that commission meeting, and remember those people sitting there and how they related or didn't relate to each other, I think we have a microcosm of some of the real difficulties, and to try to sort of create a national standard when there is so much difference, maybe the idea of beginning with some kinds of meetings to discuss to see if it can be done, many meetings to see if it can be done and if it is worth doing.

Veronica is bringing up all this whole other set of different state regulations. My sense is we are not there yet.

MS. LARSON: If I recall correctly, and I think we actually should check the testimony from February on the Education Subcommittee, that actually one of the recommendations that came out of that was a staged recommendation that said that we should move towards national standards. That was one of our recommendations that came out in February.

Now, the methods by which we will or can do this, one of the mechanisms is actually to make a recommendation for a summit, a study group that has many of these emerging professions involved in having discussion, but I think it should be a staged thing.

But I know clearly from our February meeting what came out in our workgroup on education is that we should be moving towards national, but it should be decided by the independent groups.

DR. LOW DOG: It sounded like there was -- I know they are interrelated again, but it sounded like we were saying one thing about national educational standards, but then we were also talking about practice, what you were allowed to do, if you could break the skin, if you could deliver babies, and that could be related to curriculum, I understand that, but they are a little bit different.

If you have educational standards all across, so that all schools will teach something, different states may vary on what they will allow you to do or not do, which is sort of the practice versus your education, which is what we are going to teach. Everybody is going

to have this amount of knowledge when they come out. They may have some extra or whatever, but they are going to have this minimum amount of knowledge that everybody is going to come out and agree to.

It seems like there were two different things we were talking about, education and practice. I would agree with sort of an approach that is over time, but I think your national education standards are a little bit separate than what each state is going to allow you to do. What you are saying is everybody is going to have to have this amount of training.

SISTER KERR: I was going back to the actual recommendation, but I wanted to say that, Jim, I agree with you I think on this prematurity. Again, we are dealing with national standards and diversity, and I just don't think we have evolved yet enough, because again we are coming out particularly like in acupuncture where you have such a different conceptual framework fitting into this biomedical model that I still think we are thinking out of, at least in legislation.

Maybe until this evolution of consciousness occurs in the next three years, maybe the professional

organizations ought to just keep grappling with it, but back to the recommendation.

This is just very simple. The sentence is just not clear to me, and I understand for myself that the intention was to say that the Commission recommends that national education standards for CAM da-da-da should be established by their own professional and educational institutions, isn't that correct? So, then that would be period.

And then we are saying we suggest -- I want to clarify -- that they collaborate with the proposed federal coordinating office, is that also what we are saying? Then, I think we should say it separately.

Thank you.

DR. GORDON: Michele pointed something out to me, which I think is really important, that we can advance the dialogue by talking about some of the contentious issues that are just mentioned here.

I think that if we can do that, if we can give an example, whether it is acupuncture, or it could be chiropractic, has a different set of contentious issues, if we can give a couple of examples and then talk about

how we might forward the discussion, I feel like that is as far as we can get right now. I mean that is just my opinion.

If we can do that, which is kind of what Linnea was saying, as well, that we are moving in a direction -- we may decide not to have national standards, and that is also a possibility, but I feel like this discussion needs to go ahead partly because it is so contentious.

DR. BERNIER: Well said. Linnea.

MS. LARSON: I guess I keep wanting to refer to this, again back to February. It is our decision had been to say that the professional organizations and the institutions, if they have respective educational institutions, that they would be the ones who would set the standards, and following that, if something evolves in our many public/private partnership that says these are the educational standards for X profession, that that would emerge.

But I do think it was very clearly linked and also I want to speak to what you said. There is a very clear difference between education and practice, and practice actually comes under the regulatory mechanisms

that would be under access and delivery, but I think we should spell that out very, very explicitly throughout this.

DR. GORDON: Linnea, I have a question for you. Let's say there are four different national organizations for four different sets of standards. How does that fit into what you are saying, which I think in some instances there are.

MS. LARSON: Well, I know that we took testimony in February, and I can say that I had a grid that had seven chiropractic organizations that made commentary and had very different recommendations.

I am mindful of that, but I think by saying that we do value that, that we are assisting what are called emerging professions to set a standard and to be on the same level playing field as other professions.

MS. CHANG: I will just give you a time check. You have 20 minutes.

DR. LOW DOG: I just want to make one comment since you quoted the House of Lords, just a little background in the UK, which I think is a little easier because there are not 50 states.

The herbalists over there, they had a very difficult time trying to get any sort of things moving forward in the UK, and part of the reason was everybody kept telling them, well, we have heard from several different groups, and you have all said different things.

What they told them, basically, the government, Medicines Control Agency, everybody said go home; go back, discuss this amongst yourselves, and when you can come back and speak with some sort of voice together, then we will talk to you, but right now there are so many of you, and you have so many different things to say, that we are just not going to deal with you.

It was to their disadvantage to move forward, to not be able to come up with some sort of agreements amongst themselves. It is a little background of where the House of Lords part of this, where it came from was because it says in there about overcoming internal divisions. It was the divisions amongst the practitioner groups themselves, not from outside but internal, that kept them from being able to move forward as a profession.

So, there are some valid reasons for trying to

suggest that groups and organizations try to work with each other as this would probably benefit their moving forward.

DR. GORDON: Speaking of moving forward, I really feel we need to be mindful of the time. We have several other issues that are at least as complex as these two to deal with.

DR. BERNIER: I think we will proceed to the next stop, if that is okay. That dealt with Issue 3, which was the basic or core conventional health care curriculum for CAM students and practitioners.

The background on this is that a core curriculum for CAM students has been proposed to facilitate recognition of limits of clinical expertise and potential complications of interventions and appropriate referral to conventional health care providers.

You can see the rest of that there. The recommendation that had been made was that the Commission recommends that a basic curriculum and conventional health care and medical sciences for CAM students and practitioners should be developed to facilitate

recognition of limits of clinical expertise and potential complications of interventions and appropriate referrals to conventional health care providers.

Comment on that? Yes, Veronica.

DR. GUTIERREZ: I just have one brief comment because I totally support this. The handout that I passed out from our office has a consent for care, and I support this recommendation, and as a follow up somewhere, I think we should encourage all providers to do something similar, so that every patient that enters their office knows what they can expect in the way of care and when an appropriate referral will be made.

DR. BERNIER: Thank you. Other comments, questions? Joe.

DR. FINS: That raises an issue that I think we have never discussed, and I think it's a Saturday point, that CAM therapy, there should be informed consent and refusal, and we should bring that mechanism to bear for these other interventions. I think that is just sort of an obvious point which we hadn't thought of yet, but it is important to say.

I also wanted to say one really quick thing

about Linnea's point about the professions and the House of Lords. We have to recognize, I think, in the regulation of this, and the educational piece, that some of the groups that we think might emerge as professions are never, ever truly going to get there.

We can't turn something that is not going to be a profession into a profession. It has its own sociology, and if they want to evolve and emerge, they will have the status of a profession. If they don't, they won't, and we can't turn them into that.

DR. BERNIER: We can't make them do it.

DR. FINS: We can't make them do it, and the sociological forces might be that they will never do it, but at the same time, if they are not going to do it, we should not give them the privilege that comes along with being a member of an established profession.

DR. BERNIER: Further discussion? I think we have had a poor record of accepting proposals.

DR. GORDON: George, I think that with No. 29 and with No. 30, and we haven't heard from people about 30, my sense is there is general agreement about these.

I would like some more specificity about what

we are talking about in both of them. I will just give you an example just to take and do with as a committee what you would like, but for me, what is important is that there is not just education about specific approaches in research, but that some of the education is experiential, that there is a look at the scientific literature, that there is an understanding of the philosophy and the world view, as well as the specific practices, that there is an understanding of the social and historical context of the particular approaches.

So, I would just like to add some meat to the bones of what we are talking about when we say there needs to be education about CAM practices.

DR. FINS: This recommendation was education about conventional care, at least on 29, it was the other way around.

DR. GORDON: Oh, I'm sorry, but the same way.

DR. FINS: But the more specificity that I would like to flush out is that limitation of their practice is not to provide CAM therapies to people who are, say, actively dying when, in fact, they should be made aware of the fact that they are at the end of their

lives, and they may be better off with a hospice referral.

In other words, as we said, we asked Dr. Atkins if he ever had a treatment failure, and he said no. That sense of lack of perspective of one's limitation, all of us around this table have limitations, need to be made aware of that.

So, I think it is very important that especially for vulnerable populations, and I would say that patient near the end of their life who in desperation goes to a CAM practitioner with great expense and perhaps depriving themselves of appropriate pain management and other kinds of symptom relief is somebody who they need to be made aware of these other treatment modalities that are out there. So, that kind of self-regulation is critical.

DR. GORDON: I would say that that is true -- I'm sorry I got confused here -- but I think the same thing true of people who go to CAM practitioners who have a fracture. I mean the issue is there across the board, and I think we need to make it clear. I think what we are talking about is a little more specificity for the

recommendation, but it sounds like everybody agrees.

DR. BERNIER: The time remaining for us I think is about six minutes.

MS. CHANG: About 12.

DR. BERNIER: Do they lock the doors?

MS. CHANG: I would continue until we get locked out.

DR. GORDON: I had a question about No. 30. Shouldn't we give more specificity to that or should we? Where are people with that?

DR. FINS: A lot like No. 27, which we already did recommend joint research, educational programs. So maybe we can bring those two together.

DR. GORDON: So, you are saying 30 should go with 27?

DR. FINS: Yes, and embellish both as we were sort of talking about 27.

SISTER KERR: My only comment, I don't have the answer to this, but I am appreciating Jim Gordon trying to get us to be more specific, like when we did the research part, who else but us, in terms of at a certain level.

The same, I kind of go in and out of what I am doing, like when I read 30, it is like we should encourage the collaboration and funding. Well, we knew we were going to say that. How is that specific enough, or is it that I have been into it too much? If I read this, I would say, god, they spent two years just to say we ought to encourage collaboration.

DR. GORDON: To pick up on Linnea's theme, I think that as I remember it, the workgroups in February worked out some of the specifics. Isn't that right? So, it is a matter of bringing those in.

I think even a few more specifics into the recommendation, so that people, as Charlotte is saying, they will look at the recommendation and instead of saying aha, they will say yeah.

DR. FINS: I think we really need to go back to the February meeting, because there is a lot of stuff that we actually had which needs to be resurrected. Gerri has all that stuff.

DR. BERNIER: We are at No. 31.

DR. PIZZORNO: Issue No. 4 is my responsibility. We tried to look at the somewhat unique

needs of traditional healers, and we are defining traditional healers as those who function within a community that practice both through the traditions of that community, but also with the somewhat informal oversight of the community.

Working with Buford, we tried to establish our recommendation here that we thought would be appropriate. So, that is Recommendation No. 31.

That is the Commission recommends that traditional healers who practice within a community which provides traditions and oversight should be provided appropriate access to educational funding and allowed to continue to practice without state censure providing: (a) their clients are fully informed of their training or lack thereof; (b) they do not mislead their clients by use of titles of licensed professions, and (c) have not been censured by their community.

We put the last one in there because there were examples of people who were censured by their community, then going off into other communities claiming to have you might say an implied credential, and that would lead to public harm.

So, comments from the Commissioners?

DR. BRESLER: What do you mean by "lack of training"? Is a traditional practitioner supposed to say I never went to medical school, I never went to psych graduate school, I never went to chiropractic college, I never went to naturopathy school? I mean what is the intention of your group about stipulating lack of training?

It is one thing for somebody to say what training they got. It is a whole another thing to say what they didn't get.

DR. PIZZORNO: That is a valid point. That is a valid statement.

MR. CHAPPELL: I guess I am wondering why we need to provide any differentiation for traditional healing at all, because if I am a member of a particular native community, I can apply for any as long as all the other recommendations work, I can apply like any other citizen for those same funding sources.

I don't see why we are creating -- and believe me, I am very sensitive to inclusivity here -- I don't see the benefit of creating a special case situation for

a traditional healer, because a traditional healer can get access to education if these other recommendations are enacted if they choose to.

But if they choose not to, then, they are the same status as they are now, which is the traditional healer honored by their community, fulfilling their service to their community. I think it is inappropriate for us to try to struggle here to create a special class of opportunity for a traditional healer because there is no need to. That traditional healer has access to the same opportunity as any other student for CAM education if these other recommendations pass.

DR. BERNIER: Tieraona?

DR. LOW DOG: I guess the thing would be is that we had said under the other recommendations about accredited institutions, and we talked about that there needed to be some sort of accredited school to be able to get funding, and I am not sure how much educational funding in reality a lot indigenous people are going to be seeking.

Part of this that I think is in -- well, there is an exception because on the Navajo, there is an

apprenticeship program going on now, and it is not really like an accredited kind of school, but it is a tribally-recognized program to preserve the traditions of the Navajo healing systems, and I do not believe that there is access for them for federal funding for that.

So, it is not quite the same, and the other thing is that I think that it is important, not so much on the reservation, but also for having language about urban indians where they may be living in Albuquerque and they are traditional practitioners serving the needs of native people in that community, although they are not on the reservation anymore, and I think there should be language in there, I think it is important. I think it is a different system, and I think it would also extend to Mexican-American healers, as well.

DR. BERNIER: Thank you. Any further comments?

DR. CHOW: I think we have an example of Native American healing here, but many multicultural, the Puerto Rican healers, we were talking about Ayurveda medicine, the Chinese medicine, although we have kind of, pardon the word, but, sold ourselves out and kind of broken ourselves up into components. There still is the

traditional Chinese medicine, where Buddhism in Dallas, and much of the spirituality is very much involved in it, and the Curanderos, et cetera.

I think there needs to be an emphasis on these particular systems, indigenous or multicultural systems, emphasis at this point. I think, later it might phase in, but there is a difference in educational expectations for here.

DR. BERNIER: Thank you. I think we had better end. Three minutes?

DR. GORDON: Four minutes, actually.

DR. BERNIER: Buford, could you comment on what you have heard so far about this recommendation, because you are right there in the firing line. Can you tell us what is needed, and what is not needed?

MR. ROLIN: Well, at this point I was provided some information just recently. I don't know, Tieraona, if you have seen this. It was published by the Johns Hopkins University Press for Dr. Rhodes.

In that one chapter of Dr. Rhodes, they talked about alternative medicine in the term of exploitation, and we do have some problems with that now, specifically,

and I am glad to hear that Tieraona mentioned the fact of what the Navajos are doing.

It is also happening with other tribes, as well, because of the fact we have had people who have lived on our reservations and even married into the families, who have participated in the ceremonies and have left the reservations, gone out into the urban area or metropolitan areas, established their own traditional healing.

So, it is of real concern for us now, and the fact that we have even some one of these that they are referred to in the community that this is happening with, so we are real concerned about that, and it is very important now that we continue with the training process that we have, and that is within the family on the reservation.

As we also heard from the paper that we received from the Native Alliance, the system that they use, their families and the culture, it came into being. The same thing is happening on our reservations.

But what we are real fearful of, we don't object to someone going to a sweat lodge, we never have,

but for someone to go to a sweat lodge and say that they are going through a healing, and then to go out into another community to start, yes, charging for that, we are opposed to, because normally, our traditional healers now, they don't receive any form of compensation with money. It is all part of the gifts of what you feel that you want to share with that individual for the services provided.

Unfortunately, it has been exploited in some areas, and we are concerned about that, and number of our tribes are really making an effort now to make sure that their traditional healers that practice remain within our area.

As it was also pointed out, the other issue and concern we have is we have so many of our people now who have moved into the urban areas. How do we continue to serve them?

Well, the only way they can be served now is if they go back to the reservation, but that is a concern, a genuine concern because they may have grown up where the traditional healers were included in the practice of treatment for them, and it is not available there.

But it also creates another problem, as Tieraona mentioned earlier, is those people going into another community and really not knowing what it is, the type of traditional healing that these people that lived there were involved in. It creates a problem for us, so we have some real concerns there.

Effie made a good point. There are other societies -- not societies, but I mean native people, Curanderos that she mentioned, the Puerto Ricans, and others who have their own system of traditional healing.

I think she has made a good point there, but I base this all on the fact that when we asked for those and had that hearing, we only had the few people, the few respondents that we did, but I think it is wise that we recognize that, and it is happening.

DR. GORDON: I would like to make a final point and then adjourn us to continue the discussion. One thing I want to say about this is I feel like the way that we need to treat traditional healers is with the appropriate respect.

I don't mean anybody here is disrespectful, I just mean that the way this is worded, it doesn't

appreciate the internal consistency and the longevity and indeed the tradition that we are talking about.

So, I think as we have described traditional healing practices, the more we can relate to them as they are, and as they see the difficulties, the better the recommendation that we come up will wind up being.

We can come back to this for a moment tomorrow morning. I will give up 15 of my 30 minutes tomorrow, but that still only means we have half an hour to go through the rest of these, so I urge everybody to really take a look tonight again at these last recommendations, because some of them again I think you will are very thorny, as well as knotty.

So, when we come back tomorrow, let's really try to focus on those.

Thank you both very much and we will adjourn until 8:00 tomorrow morning.

[Recessed at 5:00 p.m., to reconvene Friday, October 5, 2001, at 8:00 a.m.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE THE: White House Commission on Complementary and Alternative Medicine

HELD: October 4-6, 2001

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

DEBORAH TALLMAN, Court Reporter