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WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

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Volume II

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8:00 a.m.

Neuroscience Building
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

[8:10 a.m.]

DR. GORDON: Let's just sit here waiting for a moment, in patient waiting, and collect ourselves.

[Moment of silence observed.]

DR. GORDON: Let's begin. Good morning, everybody. Congressman Pallone, who was going to be here this morning, will likely be here later on today.

So we are going to begin. We will move right into the continuation of the section on Education and Training. They were scheduled to have, how much time, 15?

MS. CHANG: Fifteen minutes.

DR. GORDON: So we will give them 30 minutes, and take 15 of my minutes of the summation. So we will begin with 30 minutes, then we will do a summation of that, and then we will be moving on to Access and Delivery.

George and Joe, Joe.

Session IV: Education and Training of Health Care Practitioners (continued)

DR. BERNIER: Thank you, sir. We, I think, got

to Item No. 32, and I would like to ask Joe if he would carry forward.

DR. GORDON: Are we satisfied that we are okay with the traditional healing, which is where we ended up? Do you feel you have a good sense, or do we need to go back over any of that before you continue?

DR. BERNIER: I think we came to a good closure on it. It is a very difficult problem, clearly.

DR. GORDON: Okay, we will come back to that when I do the summation and see where we are. Let's move ahead, then.

DR. PIZZORNO: What we are going to try to do is to finish the last of the recommendations, and then if we have time, to go back to the other recommendations, because as a result of several conversations, and George and I working together, we believe we can make some comments here that we think we heard from the Commission. That will give direction to the Education Committee to fine tune these things. We think we heard several solutions to what was recommended.

DR. GORDON: Well, let's move through the rest of them, and then we will come back as we go over them,

and you can make the comments then. That is probably easiest.

DR. PIZZORNO: That sounds good.

No. 32, we are recommending that this be different than what you see in the document, because in many ways we felt that this was the center of a lot of the discussion yesterday. It was more on No. 32. We have some recommendations about how to do No. 32 somewhat differently.

I am not going to say specific language, because we haven't worked it out, but what we would like to do is go along a couple of themes. One is, I think we all agree that students who are enrolled in CAM institutions should be eligible for this same kind of financial support that students in other health care institutions have available to them. I am assuming that is not controversial, because a lot of that is happening right now.

There is an area where there are some kinds of loans that are only available to conventional medical students. I want to clearly differentiate between students currently enrolled, and then after graduation,

graduates being eligible for loan forgiveness programs. Those are two separate issues. I want to make sure we are not being confused.

So Issue No. 1 is: The Commission recommends that CAM students should be eligible for state, and where appropriate, national fiscal support -- my mistake. No. 32 is only about what happens after they graduate, and the language as presented here does not sound like the Commission would accept that.

We would like to propose a somewhat different recommendation, which has three components to it. One is that this loan forgiveness only be available to practitioners who have primary care licensing -- I am not saying direct access, I am saying primary care licensing; second, that it be done in the form of demonstration projects; and third, that it be done in communities where there is pairing with a conventionally trained medical doctor.

DR. GORDON: What was that again?

DR. PIZZORNO: That the idea of there being CAM professionals available in underserved or rural areas makes sense. However, it only makes sense if they have

primary care training, but not necessarily just direct access.

Primary care training means they can do physical exams, have some emergency care capabilities, be able to do a PAP smear, things of this nature. Whereas, those that simply have direct access don't have a broad enough range of skills to be appropriate in a primary care setting, in a rural setting, where there is not conventional care available; second, that this be done in the form of demonstration projects. So rather than just blanket saying, we should we do this, let's get some funding for demonstration projects.

Then, third, we recommend that they be paired, at least initially, with conventionally trained medical doctors, osteopathic doctors, in the community.

DR. LOW DOG: I would just fully support that. I think that is an excellent approach, and I think that there are certain groups that are really ready to go into that next move looking at demonstration project. I think that pairing, initially, is a good idea, and may not be necessary in the future.

But I think for the demonstration project, I

think that is just excellent. Great recommendation.

DR. PIZZORNO: Joe?

DR. FINS: We had a conversation last night, and I think that this may be the Talmudic compromise, because what it does is, ethically, it does not remove a provider from an underserved area. It is augmentation, and the hope is that with the demonstration project that one plus one is going to be equal to more than two.

For anybody who has been on call 24/7 in a rural area, having another medical provider, maybe with a different skill set, who could take first call on an alternate night and have a little bit of cross-training back and forth, might be a tremendous value-added.

I think we need to, though, demonstrate its efficacy before we make a sweeping comment about any kind of entitlement. We need to prove that in these times of emerging scarcity -- I think we really have to kind of regroup a little bit and think about the whole project in light of the national emergency we are in, and all the other claims -- everything has to be proven to be valuable. I think that the demonstration project is a step in that direction.

DR. PIZZORNO: Any other questions?

MS. GUTIERREZ: Where does that leave the chiropractor, since we don't do pelvic exams?

DR. PIZZORNO: Actually, it is excellent you brought that up, Veronica. The idea is, and a corollary to this would be, in those states where chiropractors have primary care training, they could practice independently in rural areas, or at least with a trained medical doctor. If they don't have primary care training, this would not apply to them.

The same would apply for acupuncturists. Acupuncturists may have direct access, but no primary care training. That is the compromise we are talking about here.

MS. GUTIERREZ: Define "primary care training" for me.

DR. PIZZORNO: I will let Tieraona define "primary care," because we have had this conversation several times now.

DR. LOW DOG: I think each state is quite different, because different states list acupuncturists as primary care, in New Mexico now. So different states

have different language on that.

I think that when you are looking at a demonstration project, you want to take the group to begin with that is probably going to have the most chance of success.

I think if you asked 100 people on the street, what do you expect your primary care provider to be able to do for you, I think you would get a pretty general feeling: They are supposed to be able to take care of my general health; I should be able to get my woman's exams each year from them; I should be able to have a breast exam; I should have a pelvic exam, basic lab tests; that is supposed to be the person that is able to give me my prescription for my high blood pressure medication; they should be able to meet those kinds of basic needs.

Then I think that there are all kinds of ancillary folks around that, specialists. I mean, we like the specialists too, but we don't choose them really to out into the rural areas because their skill set is also limited.

So primary care, being able to take care of the general health of the average person, really from

childhood up through elder age, because that is the reality of people out in rural areas, is that you see the whole scope.

DR. PIZZORNO: So, as I read this, again the Committee has to work on some languaging, in a state like Oregon, I believe a chiropractor would be included. In a state like Washington, they would not be included. That is the way I read how something like this would work.

MS. GUTIERREZ: Well, that is an interesting model on primary care, but in fact for purposes of Medicare, chiropractors are considered primary care, and there are a lot of patients that come into our offices who don't think of primary care as pelvic exams and prescriptive drugs, but spinal care, chiropractic care for chronic conditions, for general health and well-being.

We see a lot of people on a lot of issues. There is a whole group of people that don't see the allopathic model as their first choice for primary care, so I think this issue needs a lot more work.

DR. PIZZORNO: I am going to challenge you here. Veronica, we need to draw a line. We are not

going to put a massage therapist out in rural Washington and expect them to provide primary care, and frankly, that is probably too much to ask of the average acupuncturist too. Where do we draw the line? How do we draw the line?

So, Veronica, why don't you say something on that?

MS. GUTIERREZ: Well, I don't know how many states massage therapists are licensed in or any other provider group. I know that the naturopaths are not licensed in 50 states, but chiropractors are. So I think we should promote what is in the best interest of the public as opposed to singular professions.

DR. PIZZORNO: Well, I thought that we were trying, as I understood, to avoid the singular profession identification.

Joe Fins?

MR. CHAPPELL: I think that George called on me.

DR. PIZZORNO: Oh, I'm sorry.

MR. CHAPPELL: I guess my question is why we draw the line? Why don't we let the community draw the

line and make their choice? Why do we have to define this part? Isn't a community going to make its own selection, its own choice and decide what it wants? Why do we have to set up a more restricted set of eligibility requirements for the funding?

DR. PIZZORNO: Okay. Joe?

DR. FINS: I think the lessons of the last three or four weeks suggest that there is a role for government in protecting the public safety. I honestly think that it is up to the government to say, we are not going to spend dollars on providing access for things for people and individuals that don't provide the basic safety net.

So, I think what we need to do is to say that, yes, we are going to take this incremental step, but we are not going to be expansive, and anybody who calls themself a CAM provider is not going to be eligible, and that the organizing body that controls this demonstration project will set up criteria.

We don't need to recommend them what they are, but the testimony can be reviewed. It will be people with doctoral degrees, post-graduate training from an

accredited university with cross-training, et cetera, et cetera.

It just can't be anybody who is out there. I mean, people can be harmed by not having access to providers who are appropriately trained, and primary care is a comprehensive skill set. What we are doing here is we are trying to demonstrate the utility.

The assumption is that we have a hypothesis that perhaps a pairing of naturopathic doctors and family practitioners and internists in a rural community will be value-added. It is a speculation. It is a hypothesis. It has yet to be proven. That is what this kind of project would seek to demonstrate.

DR. PIZZORNO: Thank you, Joe. Jim and then Linnea.

DR. GORDON: I think this is an inspired idea. I think what it does is it advances something that is sensible and yet very profoundly revolutionary, and it is something that can be done and that will be responsible and that people will respond to. So, I see it as a great idea.

I just want to say I really appreciate the work

of the dialogue here yesterday, and the work that you and George, and whoever worked with you over the night, did in formulating this. It just seems like a really good idea, and I think it will work. It will work on a public level, as well, that we will be able to get public support for it. So, that is why I want to go with it.

The other thing I want to say, just, in my other role as chair, is, we have 16 minutes left. If we need a lot more discussion about this, then what we need to do is to refer it back to you and let you refine it, listening to the concerns the people have had here, and bring it back to us in December.

If everybody is ready to go, great. If we are not, let's just let it go, because we have at least four more items we have to get to.

DR. PIZZORNO: Thank you, Jim.

DR. BERNIER: I think it is clear that we as a subcommittee have to have another meeting. I think we learned a lot from yesterday's experience and a lot from last night's.

DR. PIZZORNO: Okay, we are going to move on. Thank you for your input. We will work on the language.

Oh, I'm sorry. I said Linnea could talk. Sorry.

MS. LARSON: My only comment was to say to Tom, to clarify what some of the federal programs are and how we were thinking about how to get this done. It was an issue about marketplace, et cetera, but I think we need a little bit more clarification of your workgroup to do the work on that.

DR. PIZZORNO: I think we could put some language in that kind of sets, here is the general standard and let each community, as defined by states, determine how they are going to do it and what is practitioner appropriate, because it is going to be different, state by state, depending upon the licensing, training, and things of this nature.

So, let's provide environment, let's say here is what we are trying to create, but let each community do it the way they wish. I think that should work well.

Okay, let's move on to Issue No. 6, which is basic or core CAM curriculum for conventional health care professionals at professional schools, post-graduate, and continuing education levels. We have three

recommendations here.

Oh, and a comment I want to make from yesterday's conversation about the February meetings, please realize a lot of the language in here came out of the February meetings. There was some assumption that we didn't use what was there. We used the February meetings, July meetings, et cetera.

So if you look on the three draft recommendations, after what happened yesterday, I don't know if I should say this or not, but I think these are non-controversial.

Recommendation No. 33 recommends that a basic curriculum which surveys the CAM modalities, and which probably should say CAM systems and modalities, and ensures basic skills in collaborating with or supervising CAM professionals should be developed for conventional health care professionals in professional schools, post-graduate training programs, and continuing education programs to increase knowledge and understanding of CAM in order to enhance and protect public health.

I am going to read all three of these because they all tie together. No. 34, the Commission recommends

that the curricula in CAM-funded principles should be developing at conventional health care professional schools in conjunction with CAM experts and CAM institutions.

No. 35, the Commission recommends that conventional health care providers interested in practicing a CAM modality or system of healing should obtain the necessary education in post-graduate or continuing education programs, or at accredited CAM institutions.

So is there anything in any of these three people can't live with? Jim, and then Dean.

DR. GORDON: The addition I would have, and it is really that there should be more of an emphasis on self-care in these descriptions of CAM, because I think it is too easy, especially in the context of medical education, to see CAM as simply another technique that one uses, like one uses another herb instead of a drug, and I think there needs to be some sense, even in the recommendation, that we are talking about a philosophy and a way of looking at the world, and not just about what are drug or herb interactions, even though that is

also important.

So, that is really what I would include, both in Nos. 33 and in 34, and that there be practical experience of these approaches, that it not simply be something where somebody does a lecture, this is this, this is what Chinese medicine is. So, that is my addition.

DR. PIZZORNO: Thank you. Dean.

DR. ORNISH: Joe and I were just talking that I know Bill Fair, who certainly is an ardent proponent of CAM, has expressed some concerns that there is such limited time in the medical school curriculum that he said, you know, I don't know that urologist necessarily needs to spend a lot of time learning about CAM, any more than a CAM practitioner needs to spend much time learning how to do prostatectomies. So, I just want to raise this as an issue.

Certainly it is like anything else, given unlimited funding, given unlimited time, it would be great. The question is, any time you put something into a medical curriculum, you are taking something out. If we are, in effect, mandating or strongly recommending

that something go in, then even getting in an hour nutrition lecture takes years in the curriculum.

Then you can say, well, that is part of the problem, but it is a real issue and it is something you can't just take for granted; we will just add that, because it is a zero sum game there.

DR. PIZZORNO: Donald?

DR. WARREN: In No. 33, I had something quick. It says, "or supervising CAM professionals should be developed for conventional health care professionals."

Does that mean that we look at the aspect of solo practice for a CAM practitioner as being pretty much mandated by the conventional health care practitioner?

DR. PIZZORNO: I don't think this defines practices or requires management or doesn't require management. There are just some situations where it is appropriate for a conventional practitioner to be supervising a CAM professional, and in those situations they need to know what they are doing.

Joe? I'm sorry, Jim.

DR. FINS: Just to address both of those comments from Don and from Dean, I think educational time

is scarce, and I think what the group intended here was basically to allow the allopathic practitioner to be able to work with and understand what was going on, not a completely huge world view, but to understand the relationship.

Really, in the service, the final point here is to enhance and protect the public health. So, we are not training the allopathic doctor to become a CAM practitioner -- that is not the skill set -- but just enough so they are familiar with it.

As far as supervision, there may be times where there is a supervisory relationship, but that we are not in any way mandating. That is why it is collaborating or supervising. There may be people who are in your office who are in a joint practice, so you need to know a little bit about their work and their activities.

DR. PIZZORNO: Jim and Conchita.

DR. PAZ: I think it is entirely possible to include some of this into the curriculum. The students over at University of New Mexico are already starting to experience that within their classes in various aspects.

So, even though right at this time it is

rudimentary probably, but I think in order to develop it further, it can be incorporated at various points in the curriculum, not necessarily a very comprehensive type of approach, but certainly incorporate it.

DR. PIZZORNO: Jim.

DR. GORDON: I feel very strongly about this. I think that already medical schools are doing their best with the support of NCCAM to integrate these approaches, these techniques, and this perspective into all aspects of medical education.

It can be done. We are doing it at Georgetown, which is one of the more conservative institutions on the planet, and we are integrating it into everything from anatomy and physiology to surgery and OB/GYN, and we are integrating an experience.

We can't expect physicians to know anything about self-care unless they learn it themselves. How are they ever going to learn? We can't expect them to help their patients with nutrition unless they learn something about nutrition. So, we are saying it has to be part of the curriculum.

Amazingly, once it is being said, very

conservative faculty are going along with it. They say, of course, students should know something about it. The whole world is shifting, and for us to go back and say, we really don't need to know much about it.

Phil's point, incidentally, is that he doesn't expect physicians necessarily to become acupuncturists, not that he doesn't expect them to know and have some basic experience of self-care and self-awareness and nutrition.

DR. ORNISH: I just want to clarify, I am not suggesting that this not be part of the curriculum. I am just saying that we need to be mindful of the obstacles that are there, and I think it is worth distinguishing between having an awareness of what CAM is, which I think is something all physicians should have, versus being trained in CAM modalities as part of the general medical training.

I am certainly in favor of the former, but I don't think you are in favor of the latter, either.

DR. GORDON: There is no time to train people to be acupuncturists, even if we wanted to, I agree; but I think there are certain fundamental principles and

practices that should be part of every student's education.

DR. PIZZORNO: Conchita, one final point, then we need to move on. Thank you.

DR. PAZ: One of the things to kind of keep in mind is that some of these changes are coming about because the students are requesting them.

DR. BERNIER: Most of the change is coming about because students have requested it.

DR. PIZZORNO: Okay, George.

DR. BERNIER: I come from a school that has never been judged to be too liberal, but we have really made some enormous strides during the last year in terms of exposing our medical students to the CAM philosophy and approach. Whether any of them will ever end up practicing CAM modalities is hard to say, but I think it is critical that everybody knows that CAM is out there and that it is part of the medical life.

So, thank you.

DR. PIZZORNO: Now we are going to move to the final recommendations under Issue No. 7. That is George.

DR. BERNIER: This deals with the post-graduate

and continuing education for CAM practitioners resembling the ability -- what's available for conventional health care providers. The draft recommendation is that the Commission recommends that opportunities and funding for post-graduate and continuing education resemble that of conventional health care providers should be developed for CAM practitioners providing primary care to enhance the competency and quality of health care.

Any comment on that?

SISTER KERR: My only question there was why did you say for CAM practitioners providing primary care? Why not just CAM practitioners? It is a bit back, I guess, to some of the discussion you all had before about who is doing primary care. Then, states are different, in California acupuncturists are primary care, legally defined. We aren't.

DR. BERNIER: Does anyone have thoughts on that? Joe?

DR. FINS: I think we are talking about GMP funding and tapping into that source. I think it raises the same set of questions that we raised earlier about loan forgiveness. I think that, again, given the massive

scope of recommendations in the entire report and the fact that we are facing a deficit and all those kinds of things, I think we need to focus in on the thing that will demonstrate the utility first and foremost.

So, I think that this may be something that we will evolve toward. Maybe this goes into the background piece, that, should the demonstration project be effective and show utility, these are the kinds of additional resources that might be marshaled prospectively, going forward. But it should not be a recommendation, I think, at this point because we have not demonstrated the utility of it.

SISTER KERR: I disagree, totally.

DR. GORDON: I didn't understand. Are you suggesting there be demonstrations in this area?

DR. FINS: No. I am saying that you are tapping into funds here that are for residency training programs, as I read here.

Is that right, George, post-graduate?

DR. BERNIER: Post-graduate, yes.

DR. FINS: It is really funds for residency training. What we need to show is that people who have

that set of training really have a positive impact through the demonstration projects. If we show that, then this might be a direction that we would move towards.

DR. LOW DOG: I think the recommendation is unclear where the funding would come from. I think that if you want to go to a master's degree or a doctorate degree. I know this from my own family, from my own kids, there is certainly funding available. You can apply for loans, and you can get scholarships and things like that.

To me, the recommendation isn't really spelling out residency, and it is not specifying GMP. I think that if that is what you are saying, that needs to be more clear. I think that the opportunities for post-graduate training and continuing education should be for anyone in any profession, but I would argue that there are funds already available for people to go and to get funding.

If they are being discriminated against for that, then you should be able to get the loans just like you would to go to university and get your master's

degree. I would support that fully, to be eligible for loans, and if that is not the case, then I think a recommendation should be made, that if you are an acupuncturist and you are going to do further training, that you should be able to get a loan for that, just like my son who wants to go get a master's degree, he will have to take a loan out for that.

If you are saying something separate about residency, I think we just need to clarify that and put that in a second recommendation, if it is coming from GMP.

DR. BERNIER: Okay. How would you phrase that?

DR. LOW DOG: I am not on your committee.

[Laughter.]

DR. LOW DOG: I have to do my own committee, George. But what I am saying is, it seems like there are two issues here. One is, if you are a chiropractor, an acupuncturist, massage, whatever type of practitioner you are, if you want to further your education, I think that you should be eligible for the funds to do that. I think that there should be funds.

If we are talking about GMP, and residencies,

and all of that kind of stuff, I think that is a little bit of a separate issue, and I think you need to have two recommendations so that everybody is covered by this.

I would also say that it is difficult when we can't get national education standards, when we can't get people to agree on even what the education is, it is hard then to try to set up residencies, post-graduates, because everybody is different, nobody wants to agree. This is coming back yesterday, to trying to come to some agreement for national standards.

DR. BERNIER: Thanks, Tieraona. Ming?

DR. TIAN: I think it was very important to provide any support for CAM practitioners to learn conventional medicine and to have post-doctorate training, but, again, in this you are talking about providing primary care, you ask CAM practitioners to do that, that seems to be too much, because you have to go back to medical school to do that.

Also, for instance, as an acupuncturist, that is an expert, a specialist. The specialist does not want to take the responsibility to do the primary care, because there is too much responsibility.

So, it is impossible, because the training in this country for acupuncturist is 1,750 hours, something like that, for non-physician training to be a licensed or a registered acupuncturist, compared with the system in China, it is different, the typical government five years formal training would be 5,000 to 6,000 for Chinese medical doctors, and also they have training.

DR. GORDON: It is time. We have 15 minutes left to summarize. This is clearly not an issue we have reached consensus on, so this is one of those issues that I am going to get back to the committee.

I don't like interrupting people, but we have already cut down the time for summary to 15 minutes from 30 minutes, and I want to make sure that we are all on the same page.

The other thing that I want to emphasize is that even though Tieraona is not on this committee, in effect we are all sort of ex-officio potentially on all the committees. The way we are going to help the committees move ahead is by helping them where we have a strength or an idea or an interpretation, they need our input on this.

So, let me go through these and see where we are, because I think we are going to be giving you back a few things, as you well recognize.

No. 26. Once the last part of that statement was eliminated, the part from "by amending" on, there was general agreement to No. 26.

If everyone can read the first part: "The Commission recommends that appropriate access to funding and other resources for CAM faculty curriculum program development at CAM and conventional accredited institutions and by licensed professions should be made possible." There was agreement for that.

No. 27. There was this general sense of agreement, but more detail was needed, and the question about the research was how we are going to put this together with research recommendations here.

If it seems I've left out something, or something seems awry, please just let me know. I am just going through this.

DR. FINS: On No. 27, I think Joe had added practitioners and institutions.

DR. GORDON: Okay. Thank you, Joe.

No. 28 --

DR. KACZMARCZYK: Jim, excuse me. Was No. 27 accepted with changes?

DR. GORDON: That is what I understood.

DR. KACZMARCZYK: Just asking for clarification. Thank you.

DR. GORDON: Just asking for more detail, more sort of about what it might be like.

No. 28. There were a lot of questions about this, and the general sense was this needed to be sent back and reworked, and there needed to be a discussion about pilot projects, staging states' rights, et cetera, those were three of the major issues that were raised for No. 28.

DR. PIZZORNO: Jim, I think the message that we heard loudly was there should be some kind of an incremental process here.

DR. GORDON: Yes. That is what I meant by staging.

No. 29. There was basic agreement, but again a sense of more detail being needed.

DR. PIZZORNO: Jim, could I stop you there?

There was a conversation that George and I had on this, and that is -- and this may be something that the Commission needs to discuss in general -- is, we felt to go much further in this, we were starting to become prescriptive, and we thought we were supposed to not be prescriptive.

So, we are not sure how to do this in a manner that doesn't cross over some kind of a boundary here for what the Commission could be doing.

DR. GORDON: Joe?

DR. FINS: I think perhaps in the background section you could flesh out the need and maybe give an example, and yet have the recommendation of people being aware of the kinds of issues that you raise, but not initially saying how it occurs but as background to the recommendation.

MS. CHANG: I also have a note that this one was suggested to be merged with No. 27.

DR. GORDON: No, with No. 30.

MS. CHANG: Was it No. 30?

DR. GORDON: With No. 30.

Any other suggestions about this? It is clear

that it needs the merging, Joe's suggestion about background. Anything else on this?

[No response.]

DR. FINS: Again, in the background piece, I would really very much like something mentioned about the needs of dying patients and how the practitioner needs to be aware, the CAM practitioner, of that vulnerable population.

I completely agree with Joe's point from yesterday, that that oncologist who is giving a patient who is dying another round of chemotherapy and not making a referral to the hospice, so too, needs to recognize the limits of his or her intervention.

DR. GORDON: I will tell you my feeling about that is that there are many, many vulnerable populations for many different reasons, and I don't think it serves us to keep singling out one population.

I think we can talk about vulnerability, give a number of examples, people with chronic pain are enormously vulnerable. I mean, it is just the whole variety of different people, kids with Attention Deficit Disorder. Whenever the problem becomes insistent or

terrifying, either one, there is a vulnerability.

So, I think we can address the issue and address the different populations.

DR. FINS: Maybe for Saturday, we might want to have a section in the background piece for Jim, or something in the beginning about populations that use CAM, and vulnerable populations that use CAM, not just by demographics and ethnic groups as we have discussed it, but based on illness situations or disabilities or problems that people have.

DR. GORDON: I think that is a good idea, rather than keeping on repeating the same thing over and over again.

No. 31. Again, this is my strong feeling -- I just want to check it with everyone else -- that there is a sense that the way the recommendation is worded does not have the appropriate sense of respect for traditional healers, and that it is sort of "allowed to continue to practice." I think that there needs to be something, a much more positive kind of statement, and a real framing of the role of traditional healers here that just is not done.

Tieraona?

DR. LOW DOG: I just wanted to raise one issue, because I don't think we really addressed it. We focused on indigenous practitioners of this country, but it is one of those sort of slippery slopes that you could get people claiming to be a traditional healer from anywhere in anything, and I don't think that was adequately addressed in this piece.

DR. GORDON: Buford also spoke about the issue of traditional healers coming into the cities and what happens there, and also about issues of training. So, it is a much more complicated issue than is framed here.

Dean, go ahead.

DR. ORNISH: I was just going to second what you both just said. It makes me really uncomfortable that it is almost like carte blanche to say if you are a traditional healer there is no licensure, there is no certification, there is no oversight.

In the past, there has been less need for that because of the nature of traditional healing. The apprentice, the teacher, the oversight is embedded in that system, but as that system breaks down with the

fragmentation of the traditional social supports and networks that used to provide those kinds of checks and balances. You see that with spiritual teachers too, and a lot of abuses with that.

So, my own particular bias would be to say, I don't see why traditional healers should be in a separate category. Rather, I think my recommendation for recommendations would be that traditional healers work together to develop their own formalization and certification, or licensure, or whatever form that takes.

There is no reason why they need to be in a separate category, any more than any other CAM modality does. I think it is really necessary to address that.

DR. GORDON: What we are looking for now, and this is clearly an issue on which there are a lot of feelings and thoughts, is for information and guidance for the committee to take back. So, please go ahead with that in mind.

Joe and then Tom.

DR. FINS: I hear Dean's point, and I agree with you, but I am also very sensitive to the fact that this is a kind of religious expression. I mean, there is

a traditional healer, and then there is a traditional healer who is perceived as a religious presence as well, and we would not want to constrain the expression of religious freedom.

I think that we need to wrap that language in here. Using traditional methods of healing versus being perceived as a clergy-person, I think, puts you in a different category, and communities recognize their religious leaders. So that might be a way of parsing that out.

DR. GORDON: Tom.

MR. CHAPPELL: I would hope that the edits to this would leave to the traditional communities their ways, their standings, and that we don't try to shape any eligibility that they might have for anything.

So, as I said yesterday, and I concur with Dean, I don't yet see a justification for a creation of this particular recommendation, unless we simply want to affirm that we want traditional healers to be eligible to the same opportunities that anyone interested wants to obtain through education and training.

DR. GORDON: I'm sorry, we are going to have to

move on. I just want to say one background piece of information. At a number of hearings, we had traditional healers come to us and express their deep concern that, as we move into the whole area of CAM, their rights to practice were going to be limited.

So, I feel we need to make a statement. I think we heard that over and over again from many different communities. We very clearly need to make a statement. It is a complex issue.

I would ask everyone who is interested to talk with Joe and George, and to participate.

Real brief, because we have several more issues.

DR. LOW DOG: I just think that the other thing you do need to check is that I do believe the issue of Native Americans practicing on the reservation really is not the purview of this Commission or anybody else, because they are sovereign nations, and they can sanction their own laws. So, you are really talking about traditional healers off the reservation in how you define traditional community.

DR. GORDON: Right. Also traditional healers

from other communities besides Native Americans.

DR. TIAN: Quick question.

DR. GORDON: Very quick, Ming.

DR. TIAN: What is the definition of "traditional healer"?

DR. GORDON: Good point. You want them to develop a definition?

DR. TIAN: Yes.

DR. GORDON: Will you help them?

DR. PIZZORNO: I need to ask a question here, and, George, you may also.

First of all, we do have a definition here. We need to get a clear sense from the Commission. We believe there is a fundamental difference here, that there is one group that practices traditions within their community and that community provides oversight. That group has specific needs, and I have, personally, a high level of comfort with that group. Once those people leave that community, I have discomfort.

In addition, there may be traditional healers that may come from other countries and such, but if they are not practicing within a community that provides

oversight, and you might say censure where necessary, then we don't have the protection.

So, I want to get a clear message from the Commission here. Is there a separate group that we can identify and appropriately support and protect, or not?

DR. GORDON: Tieraona, do you want to speak into the mike?

DR. LOW DOG: I would just make the language more clear about that, because "community" refers to a group of people versus a geographical location, and how you define "community". I think it just needs some tightening up, because the one thing you don't want to see is continued abuse, of people that actually do not belong to a community claiming that they do, and then hiding behind that as a way of not having to conform, to belong to a group.

DR. ORNISH: I just don't see why traditional healers are in their own category, why it is different than Chinese medicine or naturopathic medicine, or any other kind of medicine. I mean, these all come out of traditional healing communities. They all have a basis that goes back, for many of them, thousands of years.

To identify one particular group of people as somehow being 007, that they don't need to have any kind of oversight or licensure or certification, I am really uncomfortable with that and don't see the need for it.

I think it, in some ways, detracts from the strength of the other recommendations that you have, and I am not even sure it belongs in Education and Training, anyway. It seems to me to be more in the Licensure and Certification section.

I am afraid that you have got an easy target here that might take away some of the credibility of the other recommendations that are so useful.

DR. GORDON: This is clearly a rich and complex area. I think that Dean's point is one we need to consider, and I also feel that those who are traditional healers here, Steve was suggesting that there should be significant input from all of you to the committee on this particular issue. They may want to schedule a particular call in which all those here who are traditional healers can participate in that call, and address this particular issue.

We have been asked by Santeria practitioners,

Native American practitioners in cities, Curanderos, and others to make a statement. So, I feel it is our responsibility to do that, whatever the statement may be. I think it could be in Licensure. I think that is something that should be discussed, but it does have to do with training, as well.

Buford talked about this, as well as a number of the healers, talked about the kind of training. So maybe there can be a discussion, with the people who are doing licensure, about this issue as well.

So maybe, Linnea, since you are particularly interested in licensure, you can participate in this as well.

Joe, we have got to move on. We have one minute left to go through this, and I don't want to take away time.

No. 32. This is clearly complex. We will make sure we set aside time next time, and maybe if you could come up with a couple of options, a couple of ways to consider this, taking into account Dean's thought about licensure.

No. 32. There was a revised version, which we

are looking forward to seeing in writing and to talk about next time of that, relating to demonstration programs.

Nos. 33, 34, 35. There was concern for making this a little more specific, getting a little bit more feeling for it, perhaps providing some of the background for what is already happening at medical schools around the country.

No. 36. I think there is still a good deal of unclarity about this whole No. 36 and No. 37 issue. The way I read this, this does not have to do with the substantive things. One is with funding of opportunities, and the other is with the possibility of programs, specific kinds of mixed residency programs, for example. Like, David Eisenberg has a kind of fellowship program up at Harvard, with chiropractors and MDs and acupuncturists in it.

So my sense from the discussion is that you need to address the two things, one is what kind of loans, ordinary loans, should be available to people as they pursue post-graduate education, and then the other is, are you recommending that there be programs --

hearing some of the difficulties, but perhaps also some of the possibilities -- programs in which people of different professions have post-graduate education together.

That is the implication of No. 37, which I don't think is spelled out.

DR. BERNIER: That is right. We didn't really get to it, but you are right, Jim.

DR. GORDON: We have time for very quick comments, because we are over our time.

Go ahead, Veronica, and then Joe.

MS. GUTIERREZ: I would like to request that the committee define the phrase "primary care" for our next meeting, because I have given a lot of thought, and I can't figure out how a CAM provider would do a pelvic and breast exam differently than a traditional medical doctor.

DR. FINS: They are trained to do it.

DR. GORDON: In No. 36 and No. 37, primary care is not in those two recommendations. It is in an earlier recommendation.

DR. BERNIER: It is in No. 36.

DR. GORDON: Can this input be given to the committee? Because we really need to move on. I don't want to shortchange.

What I would appreciate is if all of you who have something to say could speak with the committee members. We are going to be shortchanging one group to serve this group. I would really like for us to stop any further input. Please give it to Joe and George and Joe K., and they can move ahead with it.

Thank you very much, both for your presentations and your willingness to really rethink and look at this very important area.

DR. BERNIER: We want to thank the Commission for giving us the extra chance. Thanks.

[Applause.]

MS. CHANG: The facilitators for the next section asked for one minute for a bathroom break, then we are going to move immediately into Access and Delivery. The facilitators are Dr. Joseph Fins and Linnea Larson, and I was the staff lead. We will be moving down there in a second.

[Recess.]

Session V: Access and Delivery for CAM

MS. LARSON: I would like to begin this session, Access -- I was going to say Access and Discovery -- it is Access and Delivery, and we will discover quite a few things, I hope.

My co-facilitator, Joe Fins, will be here presently. I want to thank all of the members of the workgroup and name them, Buford Rolin and George DeVries, Conchita Paz, Joe Pizzorno -- let's see, who else -- Julia Scott and, of course, Joe Fins. Thank you for working quite diligently and answering most of all the conference calls.

DR. FINS: We also want to thank Michele for an absolutely superb job with this on short notice and some very complicated issues, and I think we are all indebted to her, on the subcommittee. So thank you very much for that.

MS. LARSON: Our group has Recommendation Nos. 38 through 49. We have two placeholders, which we do need to do some further discussion on about why we have those placeholders here. I want to give a small overview about the concept and the process that we came to on

access and delivery, and how we framed the issues of access.

One of the significant things is that access actually refers to who is available and what is affordable, and then the logic of it was, this is basically a regulatory activity and we will be looking at legal authority, which then leads to the issue of licensure.

That is how we are just cutting straight to the heart of the matter, putting licensure right on the table. So, if you looked at the reasoning or the development in the first issue, you will see those issues kind of played out.

I thank Michele for this. She alerted us to this excellent report done by the Pew Foundation in 1995, that did a pretty thorough job looking at regulation in the health care workforce. I hope that people had some time to review that document, because it really helps and adds some substance to the recommendations that we have focused on.

Do you have anything to add to this one?

MS. CHANG: I just want to add that that report

has been updated. It is in your briefing books. It has been updated, and we are in touch with the group that is working with that report. They have begun to address some issues around what they call emerging professions, so we will continue our research into this background piece and offer that as part of the background for this section.

MS. LARSON: I want us to take a look directly at issues on licensure and specifically page 6, so we get come clarity of definitions. This was material provided by Michael Cohen in his testimony, I believe it was in December -- February.

Talking a little bit about the process. It took us a while, as a workgroup, to actually be clear with each other about what licensure meant and what were the different issues around certification versus licensure versus registration, et cetera, and that is one thing the Pew Report actually points out is there is not uniformity in the terms, what defines certification or licensure or registration from state to state, but this is the general model of what constitutes licensure.

SISTER KERR: Just a clarifying question, and I

will speak to this later, but did you use the guiding principles as sort of a check off for whether or not these recommendations are consistent with the values of the Commission or what we are pursuing, because I know this area is almost in some way a little different, but yet -- so, just if you could answer that?

MS. LARSON: I can say, just answering you personally, I am not going to answer for any other member of the workgroup, that I did not directly refer to the guiding principles in my conversations in my conference calls. I do not believe that I was not mindful of the guiding principles, but if you can point out maybe where I have, then please do.

DR. FINS: I think this section is really fleshing out options and ranges of alternatives. We didn't necessarily come down on what a state should do, because, as we will get to, it is a states' rights issue, and we felt that we could advance the discussion by laying out the range of options that exist, the kinds of possibilities for really the regulation of CAM practice. In that, I think not explicitly but I think implicitly, we were informed by the need to protect the public

health, to promote access, to foster choice, which are three of our important guiding principles.

Also, we didn't want to have one-size-fits-all. In other words, we didn't want to say that everybody needed to have mandatory licensure if, for example, they were doing something that could have a lower level of regulation because it would increase choice. On the other hand, if they were doing something that had a higher public health risk, for example, then they may need a higher level of regulation, so it was kind of balancing access and safety, and that was the pendulum. We tried to just flesh out the options, so that states, in making their determinations, could find the right balance for themselves.

Now, there will be variation from state to state, but that is a federalist issue.

MS. LARSON: I would like to make this additional comment. One of the great difficulties is being not only clear but be inclusive, and being quite mindful of what we, as a Commission, can be able to say to people and to states and also the recognition that states do have the power and the right to set their own

rules and regulations for licensing, but also clearly stating that we want to get to the point where the emerging professions and the professions that already have formed have the necessary regulatory overview or oversight.

Actually, I would like to ask any of the workgroup members, anyone else, if they have comments to make on this particular document?

DR. PIZZORNO: I just want to say I found the Pew Commission Report extremely helpful and very insightful, because I think it provided a pretty objective and compelling way of looking at this whole area of licensure.

DR. GORDON: I just wanted to mention one thing. There was a follow-up on the Pew Commission Report that I was on on licensure and accreditation, there was a task force on that, and it might be good to get hold of that, because we specifically addressed CAM professions.

MS. CHANG: We actually are in touch with them to discuss that.

DR. GORDON: Great. Good.

MS. LARSON: Yes, George?

DR. GORDON: I just want to say I thought it was a terrific subcommittee and that you did a great job in running it.

MS. LARSON: Thank you for your gracious comments. I will accept them.

I want to solicit commentary from the workgroup again.

No more commentary at this time, so let's go directly, I believe, to the recommendations under Access and Delivery, then maybe we will work backwards.

DR. FINS: The first is on page 8. It is Recommendation No. 38, and it needs to be edited just slightly. The Commission doesn't endorse the Report, but it concurs with the recommendations in finding it especially relevant to the regulation of CAM practices.

Again, the language that is throughout here is soft language to the states, recognizing our federal constraints. States are encouraged to use these recommendations as guidance in developing regulations for CAM practitioners.

Any thoughts or comments? Yes.

DR. GORDON: Joe, a statement like that, I feel you need to give a sense of what that means, even in the piece. Somehow it is got to be tied in, what is that all about, and in some pithy way, it seems to me, so that the recommendation, standing on its own, will make sense as a recommendation.

The other thing I would like, as a piece perhaps for background, is who cares about the Pew Commission anyway, because the way it is presented here, it is just like, okay, they said it, so let's do it.

DR. FINS: Good point. I think we need to say who was on it, and what was their charge, and a little bit of background. If you look on pages 6 and 7, on the Challenges section that leads up to these recommendations that we didn't go through in the interest of time, we are making the argument about why there is a need for this regulatory approach.

So it is there. It is set up. The ambiguity and variance, and the need for legal authority, conflicting practices from state to state, et cetera, et cetera. So, it is on page 7.

DR. GORDON: I think that part was very well

done. I think the issue is why are we quoting another report.

MS. LARSON: May I answer this?

DR. FINS: Please.

MS. LARSON: This is for clarification. The other day I made a suggestion to Tom Chapel and to Wayne Jonas regarding contextualizing their use of crossing the quality chasm, and the similarity of the guiding principles in that document and our 10 guiding principles, and I requested that they flesh that out in more detail.

And that is specifically what you are asking. Thank you.

DR. FINS: I think, Jim, there is another value to this, another group that did not necessarily have the perception of ideological baggage that this group has has made recommendations, just like the IOM has a kind of the imprimatur of that great institution. So, I think that is why we are trying to find linkages, that we didn't just develop this out of the box with a kind of ideological slant.

DR. GORDON: Right. I am in agreement. I just

think it needs to be made clear, and where the authority of the Pew Commission comes from, and how interesting it is that coming from where they are coming from and us coming from where we are coming from, there is so much agreement.

MS. LARSON: I totally agree.

DR. FINS: Other points on No. 38, with those additions and recommendations? Effie?

DR. CHOW: I really think it is important utilizing the existing concept that has been derived from traditional means. I think it is also important, then, to delineate what is special with CAM, and not to be seen as, well, there is that, so it is spoken already.

So, we need to be very clear to delineate what is special about CAM that goes beyond this.

DR. FINS: Good point. That, in fact, is what the subsequent recommendations seek to do. The Pew Commission Report was not exclusively, in any way, focused on CAM, it was really a generic health care workforce report, so we are adapting that and modifying it for the CAM context.

Maybe it would be helpful, since No. 38 is sort

of a generic statement to go to this specificity that Effie is talking about and go to the next recommendation, which begins to flesh that out.

No. 39 is that we recommend that CAM practitioners who demonstrate appropriate competency based on established standards, such as education and training, should have the legal authority to practice.

Now, there is a lot embedded in here, and we may need to flesh it out some more, but basically we are making a quid pro quo argument, if you have education and you have training and you satisfy those recommendations or regulations, based on your state, then you should have the legal authority to practice what you worked so hard to achieve.

So, it is not that people can just practice, they have to demonstrate the competency and the educational training, and it is a quid pro quo. It is a relational kind of authority.

DR. WARREN: Established standards. The states aren't going to establish those standards. It is going to be the professional groups that establish standards, and it is like we have heard, we can't get a solid voice

from any of these groups, we have got such fragmentation.

Another thing I want to ask, this Pew Report is phenomenal, but yet it was done in 1995 and I haven't heard squat about it since then. What has happened with it? Has it been swept under the carpet? If it is, are we going to attach ourselves to a sinking ship?

MS. CHANG: Actually, let me address that because, as I mentioned before, they have done an update of this, there are more recent publications that are in progress that we are talking to them about, and, in fact, that may have more relevance to CAM because they are addressing some what they are calling emerging professions.

DR. WARREN: We are not going to rewrite the Pew Report, then?

MS. CHANG: No. They are not rewriting it, but we a re in touch with them. Between October and December, we will do a little bit more background and add more background on what has been done since 1995.

DR. WARREN: Okay.

MS. LARSON: I think he was asking the question about association with why wasn't this report known

widely and an association.

I actually want to answer. I actually do not know why, and I don't know to what communities and to whom it was given and who has read it. On the second issue, too, about association, this is my belief, it is not done by proof, is I think that a body that has been given the task of coming up with those recommendations and the rigor at which it was done, and certainly that document is substantial, I think it would be a pretty positive association.

DR. GORDON: Don, I just want to mention the task force, there were task forces that followed the Report. The one I sat on was one of those task forces, and it was specifically focused on licensure and credentialing, and I think that report may give some specifics here.

I can't answer for the whole report. It is a difficult process to get people to pay attention to reports. With the licensure and credentialing, what we tried to do is just to go to the different state licensing boards, present it to them, have Pew staff talk with them or the task force on the health professions,

UCSF health professions divisions, talk with them. So, it is a complicated process, and I think the illuminating part, of course we are going to have to deal with the same issues, how are we going to get our report -- and this is something we need to be talking about as we move ahead -- how do we get our report, however hopefully brilliant it is, to have that kind of effect where we want it to have an effect.

DR. WARREN: It will be hard to buck the good old boy syndrome. I mean, to try to put something in, to get some board or regulatory body to accept, because it was given by some outside entity, it wasn't one of the good old boys that came up with it. Does that make sense? It is Arkansas slang.

MS. LARSON: It makes an awful lot of sense. I would actually like to come back to that with your explanation to me this morning, but Tom does have a comment to make, and so does Ti. So, in that order.

Tom, please?

MR. CHAPPELL: I am thinking about how we can incorporate the Pew recommendations into our language and our document, and my recommendation of how we do that is

to claim each recommendation with citation to the Pew document, but to build on the recommendation with just focused language on the CAM profession.

I think it is very important to incorporate the recommendations into our document and to cite Pew, and then to direct that recommendation specifically to CAM issues and practices.

DR. FINS: I think that is really helpful, and maybe as a generic statement for all of the recommendations. The way we have basically done it, we have made an argument about the challenges, then we make the recommendation. It seems to me that what Tom is suggesting is that we have a justification underneath the recommendation, where, in this case, we would cite the Pew Report and that relationship, but in other parts of the Report, we would just argue why this is justified, why a demonstration project would be justified.

MR. CHAPPELL: But this way, you own it, and it is your material when you hand it out. You are citing another report.

The other thing I want to say is the more we can get foundations to do focused research in any one of

the topic areas of our domain would be fantastic. I mean, just because we have committees and just because we have given some time to it doesn't mean we are the experts on these things. It really is great that there has been some private foundation money here given to focus on something, and look at the clarity of thought that came out of it. It is a good model.

DR. LOW DOG: I just wanted to go back to Don's original comment, question, statement, which was about based on established standards and the fact that they vary so much, in states that are looking at this, where do they look when there are so many, and is there any way to make this more clear, and does it raise some of the other issues that we have talked about earlier, as well.

DR. FINS: We spent a lot of time talking about this mechanism. I don't think it made it into the Report, but, first of all, we wanted to advance the framework and the options that states would have. In other words, we think if they read this, they will be a little bit further along in making those determinations, what are the appropriate standards and how do you orchestrate this.

We talked about the uniform code, and there is a body that is sort of extra-governmental, appointed by governors, that get together, that help states write their laws, drawing upon the collective experience of other states. So, we can put some of that stuff in as possibly the kinds of fora that would be used to have these discussions.

But I think Don's point shows the interrelationship between all the things that we are talking about that an emerging profession that is not yet a profession that doesn't have a consensus on what the standards are may not be the kind of entity that would qualify for the highest degree of licensure. It just may not be there yet.

So, it all goes back and forth with education and whether or not a practitioner is part of an established profession or not. I think we can't force things. Things are going to evolve over time. I think our job is to help set up mechanisms within government, within the federal and encourage the states, so that when practitioners evolve to the next level, there is a receptive mechanism for them to go to the next step of

regulatory oversight.

MS. LARSON: I am going to read No. 40:

"The Commission urges states to include a diversity of qualified CAM practitioners on any workgroup, task force, or regulatory body established to review regulations and clinical practices to make the regulatory process accountable and transparent to the public.

"The Commission urges states to utilize a broad base of representation, including allopathic clinicians, consumers, and payers of health care, as appropriate."

DR. GORDON: I am not sure I understand why you are singling out allopathic clinicians in the second sentence. I mean, to me it would be CAM. It has a slight feeling of the allopathic physicians being the supervisors of the process, and I would rather have them as part of the mix.

MS. LARSON: I would like to speak to that with a little bit of history, and if memory proves me correct, I believe that that was one piece that, actually, Joe Pizzorno added.

Can you speak to that? Is my memory correct?

DR. PIZZORNO: I think the intent was probably similar to what Jim was saying, that is, we want conventional practitioners, we want CAM practitioners, and we want the public involved in making these decisions together in regulatory processes, that's all.

DR. FINS: The background model for that was basically some of the state medical boards that were persecuting doctors who were using pain medicines appropriately, and the recommendation in many states, including New York, was to have palliative care doctors on those review committees to sort of have expertise.

So, basically we just want to have those oversight bodies appropriately constituted.

DR. GORDON: I think it has got to be worded a little more clearly, because one of the major battles that goes on with licensure is who is going to be in charge of whom when there is a new profession coming in. So, when the massage therapists in Maryland come in, they don't have their own board. They are under the chiropractic board, and that has certain strong implications. In D.C., when the acupuncturists came in, acupuncturists were under the Medical Board, and that had

certain implications.

I don't think we are in disagreement. I just think we have to be very careful about the way it is worded, so it doesn't look like one group is going to be in charge necessarily of the other.

DR. FINS: Jim, are you proposing at this stage that we make a recommendation that a state would be encouraged to have each profession have its own board? Or, a more incremental approach?

DR. GORDON: I think it may be different in different places. I think the fact that there are two sentences here implies that somehow the second sentence is addressing a different issue from the first sentence.

In the second sentence -- this is a matter of wording, and I want to make sure it is not a matter of meaning -- in the second sentence, only allopathic clinicians are mentioned; and in the first sentence, allopathic clinicians are not mentioned. So, instead of having everybody involved in the process, it looks like there are two separate processes.

DR. LOW DOG: So, just make maybe one sentence. The Commission urges states to include a diversity of