a soldier, what the VA is doing for you. I feel that that is a terrific recommendation.

No. 63. I think, again, following Tom's lead, I think there should be an action step, and I think there should be money to pay for inclusion. It is amazing if you give people $25- or $50,000 what you can get into a conference. A very small amount of money, you can begin.

I think the terrific example that was given to us was of getting issues of spirituality into medical school curricula, Templeton Foundation giving $10-, $15-, $25,000, and getting it in.

So, I think if we can look at ways of getting this kind of dialogue going in conferences, small grants -- it could be from NCCAM, it could be from AHCPR, it could be from HRSA, it could be different places -- that could make a huge difference. I just want to suggest an implementation step here.

MR. DEVRIES: Good recommendations. Thank you.

Others?

[No response.]

MR. DEVRIES: Okay, I think that finishes up, and I give it back to the Chair.

[Applause.]

DR. GORDON: Thank you very much for a really good job.

Let me go through this quickly. We did a lot of this work as we went along. To begin with, there was considerable interest in seeing more information, seeing the whole debate on safety and efficacy, the whole discussion, fleshed out considerably more and presented and then talked about again at our next meeting, because there was a lot of questions about that.

In terms of Recommendations Nos. 51 and 51, particularly Recommendation No. 50, again, more specifics. We are really sending this back to you for more specifics about what the nature of these kind of partnerships would be.

No. 51, although there were perhaps some of the same issues, essentially we were asking you to look at No. 51 in the same way as No. 50.

No. 52, we felt there was a stronger statement, rather than encourages. I think throughout Nos. 52 and 53, there was a sense of the more we can do to advance this agenda, the better, and that the statements have to

be stronger. But I didn't see anything in the content that needed to be changed. I may have missed something there, but I don't think so. If I did, please let me know.

No. 54. There are questions of how approaches can be integrated, what other approaches need to be added, issues of wellness come in here, issues of specific examples, there was a feeling that the group needs to work on that aspect of these recommendations.

No. 55. I think that what we said is that this wording worked, but I am not completely sure of that.

Am I right about that? That we decided that consider was the appropriate word there, after some discussion?

No. 56. Again, if there could be more action steps within No. 56, that might advance that. It seemed a little bit vague at this point, and there may be ways in reconsidering it that you can find that.

No. 57 seemed appropriate and then it looked like, again, I think what we started coming to is the more we can move in the direction of having some action steps for these recommendations that saying looking at,

what exactly does that mean, and the more you can come up with in terms of saying what that means, the further along we will be.

No. 58, which is the "encourage state government to grant legal authority to practice those CAM professions seeking license or equivalent stature." Part of No. 58 needs to go with the general discussion about licensure, but there is also an interest in some kind of state gathering, perhaps.

I think trying to put together a few of the recommendations, we can look at what we would suggest for an agenda of state health officers in some kind of meeting. We might take some of these recommendations that refer to states -- and I am trying to put it together in my own mind now -- and make a more general recommendation for the kinds of things that such a gathering might look at, pulling it out from several of the specific recommendations that were made here.

No. 59. It seemed to me that there was a significant discussion about wellness programs, and explaining a little bit more about necessity and appropriateness, and outlining necessity and

appropriateness, you raise the issue how necessity and appropriateness might relate to CAM. I think what you are hearing from us is the more of an answer that you can give, the better it will be.

No. 60. There are two sides to it. We added a second part. "The Commission encourages insurers and benefit experts, managed care organizations," et cetera, "to work cooperatively with CAM professions to develop criteria for appropriate coverage."

There is also a second issue, I think Joe raised it, of pushing, as best we can, for those groups, and we might begin -- I am just adding now as a possibility -- with federal agencies where we can have more direct input, finding out what their consumers want. This has been done sometimes.

Joe's suggestion was this should be a general kind of policy. It is not enough just to talk about the benefits, but a kind of previous step or an ongoing step is what exactly do consumers, members of these groups want for their health care.

No. 61. The website; it seems like we are in agreement.

Go ahead, Joe.

DR. FINS: One last point, it may dovetail with a patients' bill of rights about participation.

DR. GORDON: That comes very much back to our 10 principles from the beginning.

DR. FINS: Right.

DR. GORDON: I think, again, there is a sense, and I heard this particularly from Charlotte, of anchoring recommendations about coverage also in the 10 principles. So if those references can be there, that will help advance and tie together our recommendations here with our overall perspective.

No. 62. I spoke about including the health benefits for federal employees here and also providing information to the patients, to the consumers, to the people, about what benefits are available for them and what benefits are available throughout the government.

No. 63. The recommendation was to suggest an action step of providing small supplements for conferences to address some of these issues.

Are we okay?

[No response.]

DR. GORDON: Great. It is lunch time. We will adjourn until 2:00, and then we will come back and we will be addressing wellness.

[A lunch recess was taken at 1:00 p.m.]

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

[Reconvened 2:10 p.m.]

Session VII: CAM Wellness, Self-Care, and Prevention

DR. ORNISH: I want to thank the other members of this subcommittee of the Commission, Bill Fair, Julia Scott, Charlotte Kerr, Ming Tian, and Corinne as the staff lead.

Before we get into the specifics, I want to just talk about two general issues. The first was we have kind of gone back and forth about whether this should be a separate, stand-alone chapter in this report versus folded in and integrated into other sections. Part of the reason was that a lot of it is covered in other sections in one form or another, so it is inherently somewhat redundant, but also it wasn't originally part of the charge that President Clinton gave to us. So we addressed this as a stand-alone chapter. As we got into it, we decided it would be better to just weave it into everything else.

Then we heard that Dr. Steven Strauss at the NCCAM was particularly interested in this chapter and

thought it should be a separate chapter, and so we have kind of come full circle back to keeping it separate.

The other reason for the possibility of keeping it separate was to emphasize the importance that we believe in that. It gives us a chance to include the entire spectrum, from disease treatment to wellness, and to, in that context, delineate what is a commonality of most, if not all, CAM modalities that distinguish it from traditional Western allopathic medicine, which is allopathic medicine, in general, tends to stop at the absence of disease, as opposed to seeing it as a spectrum that goes much beyond that.

In our conference calls, we talked about the importance of including the entire spectrum, going beyond just absence of disease to wellness, to put it in a context that goes beyond just St. John's wort versus Prozac, for example, but getting more into the philosophical issues, beyond even wellness, of healing versus curing and even death as the possibility for transformation or illness as a catalyst for transformation that goes beyond just the physical changes, even to the point of enlightenment in some

spiritual traditions as one of the spectrum way beyond even wellness or curing disease.

So, with that as kind of a global context, we can address some of the specific issues and recommendations. Before we do that, do any of you have any comments about, in particular, whether you think this should be a separate chapter or whether you think it should be folded into other chapters? Tom.

MR. CHAPPELL: I am very pleased to see it as a separate chapter. I think self-care is a mindset of the consumer, and I think it is very different from a modality. So, it is a way of thinking, a kind of perceiving that is important to recognize in this whole system.

DR. ORNISH: Just to be devil's advocate, that mindset still could be woven in. The fact that it is a broad mindset doesn't necessarily mean it has to be a separate chapter. Are there other reasons why you would like to see that as a separate chapter?

MR. CHAPPELL: You see, I don't think it gets woven in very well. I think it needs to be separate to emphasize just how significant the shift in thinking is,

that I am not giving myself over to my doctor, I am maintaining control of my wellness, and that is very different. So, that when I am even talking with a CAM practitioner, I am still in charge as the patient. The separate nature of the chapter and the philosophy reinforces that reality that a very large percentage of consumers has.

DR. ORNISH: Thank you. Other comments?

DR. LOW DOG: I would just suggest that, if possible, that it go in after the definition and introduction. I think that the wellness and the self-care is really the fundamental part of what really we are talking about. It also is a very unifying principle, because I do think, if we are looking at Ven diagrams, I do believe that there is overlap with nutrition therapies, registered dieticians. I think that there is overlap in there, but I think it is really the foundation, really, of where we are hoping to move in the future, which is not reliance upon any one individual outside of ourselves.

If you think of the patient as being in the center and there being a circle around them for which

there is acupuncturists and doctors and priests and preachers and surgeons, they are in the center and they are all in equidistance away, which is sort of what Tom is talking about, the foci of control, but if we are all looking at them as being equal, but each person at a different time in their life will come to it, I think that is what we are talking about.

I don't know where it is supposed to be positioned, but, to me, it seems like it is so important and it is so fundamental that it should be the opening, before information dissemination, research, and all that kind of stuff, we should say, this is our foundation, this is the driving principles, and then we are going to move into all the rest from there. It is just a thought.

DR. ORNISH: Okay. Jim.

DR. GORDON: In a sense, I very much agree with Tieraona, it is one of the deepest messages that we have, the whole transformation of the health care system is predicated on a reversal of a system that does thing to and for people to one in which people act on their own behalf and then also are helpful to one another.

I think in terms of our report, I would say it

is very important to have it separate. I am not sure exactly where in the Report, it is an interesting idea to have it right up front, but I don't know about that. But I definitely feel it should be separate to call attention, and I feel it needs to be woven into all of the other sections, as well. I think that it has to be separate so that people will really pay attention and they will get it that we feel it is important and they will too, and it has to be woven in, because that is so much the spirit of all the recommendations and of our principles.

DR. ORNISH: Thank you. I agree, since it is our section, we would like it to be first, too.

Effie.

DR. CHOW: I agree with you, it should be first. One, it formulates, really, a basic foundation of our thinking, and this is what makes CAM different than the medical system that we are used to. I think it should come with the overview and this chapter.

Then the others will be based upon the premise, on how we think. I would recommend that more should be integrated into the other chapters, the research, and all

the others.

DR. ORNISH: Thanks. Any dissenting opinions, since we have so many in agreement? Since I am not there to dissent, does anyone else want to dissent?

[Laughter.]

DR. ORNISH: All right. We have a pretty clear consensus there.

Why don't we get into the specific recommendations. Corinne, did you want to add anything? Do any of the other members want to add anything?

Issue No. 1 is the utilization of CAM in schools and the community to facilitate learning, improve behavior, and optimize well-being. Since you are all familiar with the background and challenges, why don't we move directly -- and if you are not, you can read it really quickly, while you are sitting here -- why don't we move into the recommendations, beginning with No. 64?

DR. BRESLER: I didn't see anywhere where consideration was made about getting to the pediatricians or health care providers for kids, too? Was that considered by your committee?

DR. ORNISH: Actually, it is. We even have a

whole thing on school lunch programs and things related to that.

DR. BRESLER: Specifically for the health care professionals who take care of kids?

MS. AXELROD: That is actually Recommendation No. 71, so we will get to that.

DR. ORNISH: Thank you. I knew that. Tom.

MR. CHAPPELL: Thanks. I think No. 64 is a great beginning here of what the issue is. As I read about the idea of the working group, which normally sounds like such a constructive idea in a collaborative spirit, but the more I thought about it, the more I was saying, well, why aren't we asking for an imperative from the Secretary or an imperative from the President?

This has such importance that I guess I am looking for a way to make more of a pronouncement, make it appear to be more important. What is presented here is a very pragmatic idea and solution. I am just looking for something that suggests the urgency and the total value that this has an idea.

DR. ORNISH: We discussed this. Part of the issue, also, is that when talking about CAM in the

schools, this for many people can be a big, red flag. First of all, parents get very protective about what their kids are learning. For some parents, it gets into the area of spirituality, religion, separation of church and state, cults, in some people's minds.

So, what we tried to do was to find the right balance between not mandating or dictating something that might be an issue, but to try to integrate it this way. We are certainly open to any ideas that anyone else has on this.

Joe.

DR. FINS: Along those lines, I think Ti had said at an earlier meeting that it would be very careful not to proselytize. The other thing here is I worry about CAM creep, where CAM becomes public health and public health is now a subset of CAM.

So all the kinds of recommendations that you are making are really ones about health promotion, and there is a whole other part of the federal bureaucracy and scholarly areas that do not consider themselves part of CAM and see their mission as this. I know we mentioned Healthy People 2010 elsewhere, we just have to

be careful not to try to envelope the public health sector with CAM labeling.

DR. ORNISH: I agree with you. If you remember, early on, when this topic was first introduced, I was arguing that our Commission should not deal with that topic at all for that very reason.

DR. FINS: That is why they made you chairman.

DR. ORNISH: Now that I am chairman, I had to find all the reasons to look why it would be useful.

I think you can make a good case, but I do think we need to be mindful that there is a lot of overlap, not only with health promotion and disease prevention, but with several other areas, too. But than again, much of CAM does overlap with other issues. You are right, it is easier to just call everything that is not drugs and surgery CAM.

DR. FINS: Perhaps, Dean, in this particular recommendation, instead of saying, "utilize CAM principles," why don't we say, "utilize health promotion and wellness principles," which would be less alienating and less proselytizing, and I don't think would materially alter what we are recommending.

DR. ORNISH: We also misspelled principles here, unless they really meant CAM principals, like a school. I think that was not the intention.

Any comment on that before we move into others? Jim.

DR. GORDON: I agree in principle, spelled either way, with Joe. On the other hand, if you look at what is actually going on in schools, it is a horror in most schools. I think that we have an opportunity to call attention to the mess.

They may be saying things in health promotion, and I am sure they are, but nothing is happening, or virtually nothing is happening. Almost all health education in schools that I have seen is, don't do this, don't do that, don't do the other thing. The whole notion of health promotion is pretty much out the window.

I think that there is a balance between not thinking that we invented the idea, on the one hand, and on the other hand, making an extremely strong statement. I am not sure exactly what they are. I would like action steps, too. I don't know that a working group is enough, but I am not sure what else.

I don't think we should get grandiose, on the one hand, but on the other hand, I really do feel we have to do something. We will come back to the school lunches later on. Actually, we don't talk about school lunches, we just talk about high-fat snacks. The school lunches are as bad as the vending machines in many of these places.

I think that this is a place -- we have heard it in our testimony, and we all see it every day in our communities -- this is a place where we can have a real impact. So I just want to urge us to take that opportunity.

DR. ORNISH: Jim, specifically, are you recommending that we say CAM principles and practices, such as (1), (2), (3) and (4)? What are you saying exactly?

DR. GORDON: I think so, yes. We have had this discussion before and we came now down with a few things that were really important that are part of CAM but also could be seen as part of health promotion or just part of good pedagogy. The ones I would mention are nutrition, however we want to talk about stress management, physical

exercise. Right after they cut arts programs, they cut the PE programs, and self-expression.

If we have those things as a core, that we regard this as fundamental to the good health and to facilitating the education of children, then we are on very firm ground. Two million kids are on Ridlin now, and the psychiatrists, god bless them, say that six million people should be.

DR. ORNISH: So just to be clear, then, we would say something like, "to develop guidelines on how to utilize CAM principles, such as stress management, good nutrition, exercise, social support."

Those kinds of words are really bridge-building words, as opposed to things like "yoga," "meditation," which for many people are buzz words. I think that would be a useful way. Again, it kind of seizes the middle ground because then you force people to say, no, we are really kind of against exercise for kids, or, we are really against good nutrition for kids, or, we really think they should be all stressed out.

So, I think we could add that, and I think that would make it stronger.

Tieraona, you wanted to say something?

DR. LOW DOG: Actually, I had a lot of similar things to Jim. I was wondering, the reason I also thought of putting this up front, it really brings to focus, very quickly, the impact.

If we are looking at long-term health care and the cost of the budget, and the rising health care, and now Type II Diabetes we are seeing in children as young as 10 and 12 years of age because of obesity and diet, it really brings to bear, if we want healthy people in the future and we want to keep our costs down, that we are going to do this.

I don't really like how to utilize CAM principles and practices. If you want to use it, I do like health promotion, but I also think we need to be specific of what we are talking about, which, I think, is stress management, conflict resolution, physical exercise, and appropriate nutrition. I don't think anybody would argue with those. When I read, though, CAM principles and practices, it is a very big open.

I will just tell you, from our own experience and our own school with our own children, even trying to

get a tai chi class in, you would have thought we were going to be preaching in the schools. We couldn't get it, actually. We never could get it.

So, I think if you start with stress management, you use that kind of language, conflict resolution, you use those types of words, then each school can sort of figure out what method they want to use to bring that in.

DR. ORNISH: What if it were something like on how to utilize CAM principles and practices, such as stress management techniques, good nutrition, exercise, social support, conflict resolution, would you be comfortable with that?

Because the advantage of that is, particularly if this is a chapter that is early in the Report, it helps the reader who is unfamiliar with CAM to say, oh, that sounds okay. I mean, you are not talking about aromatherapy in the schools or chiropractic in the schools, or whatever it happens to be that may be more controversial.

Corinne wanted to clarify a point.

MS. AXELROD: I just wanted to mention that the

rationale for the working groups is that there is a precedent in the government that they have issued guidelines which are used throughout the country, and these guidelines have been on specific topics.

What they have done is bring together a working group, and it could be called an advisory group, or whatever, but this is the precedent that has been set for the other guidelines that have been developed, and it is actually important to bring these groups on board.

I just wanted to explain that that is why we put in here working groups.

DR. ORNISH: People who haven't commented yet? Charlotte.

SISTER KERR: Just a general statement, and I will just set the tone, though I go from yin and yang on this. I am a little concerned about us trying to be so okay with the body politic. And that is our opportunity.

This is the core orientation, wellness, for what CAM is, what is unique to CAM. Conventional medicine has its orientation, and we have a different orientation. But I believe we are about transformation, and I think we need to think about the fact that we have

got a system that is broken down and raggedy and spending us up the kazoo, and we might just have to be a little confrontational.

I know both ends of that, but I want to just put that out now so we just kind of stretch a little. We have got kids, like Jim is saying, we have got a country that needs to get its heart back, and I am just wondering if this isn't our place. Besides our overview, and our speaking of paradigm movement and who we are uniquely, that this might be our spot.

So, I invite me and all of us again to think, to feel, and to listen to what we want to do to breathe back into vitality to America through what we are calling healing. Thank you.

DR. ORNISH: If I can just respond to that briefly. I actually agree with you that there should be more in here about transformation, about illness or suffering as a catalyst for transformation, about the spectrum of disease treatment to wellness to transformation. I don't view those as confrontational, though. I don't view those as pushing people's red buttons.

In the first study I did, we called it "Effects of Yoga and a Vegetarian Diet," and we had a hard time getting referrals, so we changed it to "A Low-Fat Diet and Stress Management," that made it okay.

There are just certain terms that, for whatever reason, we can argue whether they should or shouldn't, but they just make it more difficult for people to hear what you are trying to say. But I don't think that the concept of transformation is one of them, and you all know that I am pretty sensitized to red flags. I don't see that as a red flag. I do think it is important to get that in there more explicitly than it currently is.

SISTER KERR: I value and respect your experience, and also how you continue to call that forth. I was thinking specifically of something like Tieraona just said, if we felt qigong and tai chi should begin in kindergarten.

DR. ORNISH: That, you would have a red flag with.

SISTER KERR: I understand that, but that is kind of one of my examples of we don't think that is just arbitration talk. Maybe we need to have Big Bird doing

qigong. We need to figure out how to get Big Bird, or whoever one of these people are, doing it.

DR. ORNISH: Big Bird actually does Tai Chi.

SISTER KERR: Does he, really? Great.

DR. ORNISH: Other comments? Joe.

DR. PIZZORNO: I think it is important we speak our truths, and I think there are three truths here we have to speak. One is health promotion and wellness are core to CAM philosophy. Health and wellness promotion are core to public health, and, within conventional medicine, there is an intent to result in health by treating disease.

So, I would like to modify the language a little bit that respects all these traditions but does not pretend that the CAM professions that have worked so hard to give this life in our society are not core to this whole concept. So, I would change it slightly, and that would be going down to the fifth line, it would say, "Develop guidelines on how to," insert "better utilize the health promotion and wellness principles and practices typical of CAM, such as," and put the laundry list that Jim recommended, stress reduction, exercise,

healthy diet, et cetera, "to improve students."

So, clearly we are saying there is already some of this here, it is not exclusive to CAM but it is core to CAM.

DR. ORNISH: I also think it would be worth including the fact that allopathic medicine is based on these principles, too, going back to Sir William Osler. It is only in more recent years that I think people have tended to lose sight of that. Joe.

DR. FINS: I think we to say typical of the best of allopathic and CAM practices, because, again, I don't think we want to create a dualistic and antagonistic framework here. It is really about integration. It is about building alliances between the forward-thinking people in all camps.

DR. ORNISH: And when you think about it, it would be one of the great ironies of life if we start to polarize people in the name of CAM. That is where I have been coming from in all of this, is to say that would be like killing for God. To me, it is something people do, but it kind of loses sight of the main purpose of what we are trying to talk about.

DR. PIZZORNO: With all due respect, Joe, the reason people are going to CAM professionals is because they are not getting this from conventional medicine. And, yes, I agree it is the best of conventional medicine, but that is not what is happening, with the exception of a relative minority of medical doctors, such as typical in this room.

So, let's not take away from CAM its due, and I think that does.

DR. FINS: To be quite honest, there are people who are in CAM, under the rubric of CAM, who engage in fraud and manipulate.

DR. ORNISH: Okay, okay. I am going to stop this right now.

DR. FINS: But the point is that CAM itself has a range of practitioners.

DR. ORNISH: Your points are well taken. I think, from my particular vantage point, I want to talk about integrating the best of traditional and non-traditional practices, recognizing that there are problems in every discipline.

DR. GORDON: A point of procedure, if we can

give back the basic principles and some consensus on the principles, then Dean and the small group can deal with the wording. I just think we have about nine or 10 recommendations here, and we are still on No. 1, albeit that it is very important, the question is is there information that needs to go back to that group. Clearly there are some areas of disagreement here that have been highlighted. I just want to remind everybody that the crucial thing here is for Dean and the other members of his group to hear the perspectives of all of us. Clearly we are not going to come up with the final wording right here. I don't think we should try to do that.

DR. ORNISH: But I also think that we are not so much just stuck on the first issue, we are really talking about the broader principles that will be applied.

MR. CHAPPELL: I would like to support what has been said about being more focused and specific about the types of practices, but I would also like to get back to Big Bird. I actually think this is deserving of a campaign, of a communications strategy --

DR. ORNISH: A CAM-paign?

MR. CHAPPELL: -- a communications campaign, the creation of a wellness icon, and the spokesperson that kicks this off is the Secretary of the Department of Health and Human Services.

This needs -- and thank goodness, I am your ad guy here. I know this stuff. I don't know CAM, I don't know conventional medicine, but I know how to promote ideas, and this idea is big enough to be worthy of a campaign, and I would like to see that kind of language included.

The last suggestion I have is, at my son's school when they created a meditation room, it was like letting all CAM practices in the back door. It was amazing. My son was showing me around the school, and he said, this is our meditation room. I said, oh, great. I said, do you use this? He said, oh, yeah, I come here every day around 5:00 and I stay for 20 or 30 minutes. It is amazing.

So, to be even specific about the creation of a meditation space for stress reduction is one way to just avoid this one big pill of CAM practices and be very specific and get in the door.

DR. ORNISH: Thank you. We need to move on, I am being told, and I always listen to Corinne. Effie, did you want to say something quickly?

DR. CHOW: I think that we can be leaning backwards in trying to think what will shock or not shock or create waves. I think we were created to create waves, perhaps, because of the demands of the people. I think we need to think back that we represent a broad range of people and that we use terms which are used in CAM and not water it down to what is totally accepted. I think we can bridge it by using phrases such as and then give examples of what really is.

I think we would be doing disservice and being not truthful nor representative, and that is why we had the thousand people that spoke before us, and spoke very strongly about various issues, and we need to speak to those issues, as well as the safe issues.

Using words like yoga, like qigong, like spiritual healing, I think it is our opportunity to educate the people that is going to be in the position of making decisions, but still using common and understandable language, but including some of the

others, otherwise we miss our whole purpose here of making significant changes and impacts on the system.

DR. ORNISH: I am just going to take the prerogative of responding to that briefly, because I think you have raised a really important issue, and I certainly respect your point of view. I could make a very eloquent defense of it, as well.

At the same time -- and this may help to explain why I find myself in the very unusual position of being the most conservative member of a group, where I am usually on the other end of the spectrum with any other group that I have been with, and that is what is the ultimate goal here. You touched on it, Effie, when you talked about affecting change. We can create a polemic that says everything that we want to say, and I can just tell you that it is likely to go nowhere, that it is going to offend or push so many people's buttons that we can win the battle and lose the war.

We can just say, yeah, we said exactly what we want to say and it is completely ineffectual. I think that we need to be mindful of the climate that we are in, the people who are going to be reading it, and how change

really occurs, particularly at the governmental level, which is generally incremental. If we tried to do too much, if we put things in people's faces, more than they are able to accept, I can just tell you from my own experiences, we will create such a backlash and such marginalization, that I am not sure that we will have anything to show for all this effort, other than a nice document.

I am much more concerned with actually seeing things implemented and actually changing, than having the purest document, in terms of putting everything in there that we might want to say. So, that is my particular vantage point, where I am coming from.

DR. CHOW: Excuse me. I am not a revolutionist. It is evolution, but we need to use the words that are new and to educate the people, but relate it to the words that they understand, so that you are not just throwing unknown words at them. So, I understand where you are coming from, Dean, I also have history, and all of us have history about facing changes and have been very effective, too, as well, in respect, because, otherwise, I don't think we would be here at the

Commission if we weren't mindful of exactly what you say.

So, all I am saying is that we need to be a bit more bold, like Charlotte has been saying and Tom has been saying, and not to be stating things to be safe. I think we have a problem there in really making our mark, because I don't think something like this is going to happen for another century, to have a Commission to take a look at the whole system and to be able to make the impact we have. If things aren't said in our document, then it is not going to come up afterwards, because they have to read it in the document.

I am not talking about being way out. I am talking about utilizing both terminologies.

DR. ORNISH: I understand. I don't want to belabor this, but I am not talking about being safe, I am talking about being effective, and it is different in dealing with change at the governmental level than it is in other levels that we might have been involved in. It is not that this document doesn't talk about qigong in other places, but if we are talking about, in this particular example, what we are going to teach to kids in schools, I can just tell you, if you start putting things

like meditation and qigong and other modalities of CAM, it is not a question of being safe, it is just a question of being mindful of the effect it is going to have on the readers.

DR. GORDON: I want to make just a brief comment. My experience has been there are many ways to do this. I don't think there is necessarily a contradiction. I think one can begin by using words that are quite acceptable and then show the effectiveness of a variety of different kind of techniques and bring in many techniques.

Michele was just sort of writing down some notes, with which I concur completely. There is research that shows that meditation and relaxation improves learning and decreases violence -- just 30 seconds -- I have worked in schools in D.C. We have worked in many, many schools, public, private, every imaginable kind. We have brought in everything, including working with massage on sexually abused kids, teaching them self-massage and helping them to touch others in a loving and, as they would say, nurturing way, rather than an exploitative way.

It is all how you word it, and if you give good examples and good research for using these approaches, then you can bring it in. I think that is the challenge for us.

DR. ORNISH: And that leads us into No. 65, which is the entire intent of that. Just as you were saying, Jim, again, I want to distinguish, we are not saying that we shouldn't be teaching meditation. I think we should be teaching meditation in schools, but in terms of how you convey that in a document, I think, calling it stress management in No. 65, bringing in the kind of research that you are alluding to that talks about the benefits in a variety of different circumstances, it naturally flows, in the way that Tom mentioned, in terms of putting the meditation room in the school.

But if you just say right up front, we think all schools should have a meditation room, people are going to just go, forget it, at least many people will. I think we will be less effective.

Again, it is a question of not being safe, it is a question of what is most skillful and most effective. Joe.

DR. FINS: Along those lines, perhaps we have the direction wrong. Perhaps we want to set up a mechanism or resource or use NCCAM or whatever entity it is, something in the Department of Education, to be a resource for those schools or school systems that choose, through the local process of the school board and local control, they want to access meditation or these modalities, so it comes from the community and reflects community values instead of it being imposed or proselytized from above.

DR. ORNISH: So, how would that work in practice then? How would you word that? I think it is an interesting idea.

DR. FINS: I don't have the wording quite right, but the concept is basically that we are responding to a demand or a request for assistance, an assistance program for those educational institutions that seek to begin the integrative process of bringing CAM-type modalities or wellness, depending on that semantic thing, into their school systems.

DR. ORNISH: But, frankly, I think that is going to read very well if say that we want to survey the

communities to see what they want, to empower the communities to make those kinds of choices for what is appropriate for their local community, that kind of stuff always reads very well.

DR. FINS: This kind of function could be part of a CAM central set of services that would be available under that rubric. An educational consulting service would be part of it, that would help as a resource for school systems, and of course there are different problems in first grade or twelfth grade, other kinds of challenges. But, again, it would be based on a response to a request.

If there are no requests, then we would know after a three-year study. Then we would just take it out. It wasn't meeting a real need. But if there is an increased number of requests, then we could increase the allocation. I think it satisfies what Charlotte is seeking to do, without getting into the proselytizing trap.

DR. ORNISH: Thank you. Good suggestion.

Other comments?

DR. GORDON: My sense is that this really needs

to be worked on with the group, that it is a question, I think, of making some very bold statements, but statements that are, in a way, unexceptionable, of having them backed up, Joe is bringing in another issue of local initiatives and local requests, and I think all of this has to be put together.

What is happening in this group -- this is sort of a process comment -- is we are taking on a very, very broad and very deep issue here that relates to all, as you said at the beginning, to all of the other areas that we are covering, and what we are doing is we are using our imaginations, giving us the opportunity to use our imaginations to really think about some of the broadest possible implications.

So, I think we are giving it back to you, and now the next iteration has to do with somehow synthesizing it all.

MS. AXELROD: I just wanted to get some clarification from Joe Fins about your suggestion. Are you suggesting that as an expansion of Recommendation No. 65? That actually would fit in, I think, pretty nicely with that.

DR. ORNISH: Yes, he is. Okay, good. We move on the Recommendation No. 66, and then Issue 2.

MS. AXELROD: I would like to mention on Issue No. 66 that we wanted to do a little bit of change in the language to just put it in a little bit more positive light. So, instead of saying, "be developed for schools to limit the sale and advertising," we just wanted to say something like, "to promote sale and advertising of healthy foods and products," to just put it in a positive light. So, we will change that language.

DR. GORDON: I think it has got to be stronger.

DR. ORNISH: I would recommend doing both. I would start it off by saying, "to encourage the sale and promotion of healthful foods and other products, and also to limit the sale and advertising of high-fat snacks, soft drinks, et cetera."

Even Coca-Cola really recently took out their soft drinks from schools. I think that they are really beginning to feel that the tide of public opinion is turning against that and I think we will be on effective and safe ground by putting that in there.

MR. KERR: I've always said until the mothers

got involved in the nutrition we were going to go nowhere in this country. Now there is a group of mothers who are into bringing the stuff out of the schools. They would be the people that would give you some support and help if you want to carry on.

DR. ORNISH: I also want to just clarify, having made a glib comment, that one of the things that I think we also should include in this is that what I have found so interesting in my experiences with Medicare, for example, is how these kinds of issues really transcend the usual categorizations of right wing, left wing, Democrat, Republican, these are really human issues. Empowering the individual, personal responsibility, opportunities for change and transformation, these are not categorized by any particular party affiliation or place on the political spectrum. I think that in many ways it is an opportunity to bring our country together and to get past the polarization that is so often seen in other issues. Even the fact that you had Arlen Specter and Tom Harkin coming together, I think was representative of that.

We need to move on.

MR. CHAPPELL: I am just aware that we have not addressed school lunches, and I am thinking that this No. 66 is an opportunity, we could recommend examples of healthy nutrition menus.

DR. ORNISH: I think that is a good idea.

MR. CHAPPELL: The Dr. Ornish Cookbook. I think we can empower people here without mandating.

DR. ORNISH: I agree. Let's move on.

DR. GORDON: The only other thing that might be useful to add here is that somehow to tie in -- this is a larger subject -- to tie in the whole area of health with other subjects that kids are being taught in school. For example, there is a very interesting program in Berkeley where they are working in the schools, they teach kids about nutrition, they teach them how to cook, they have a garden, they work in courses in Ecology. So, it is the whole kind of integrated program.

DR. ORNISH: That is actually Antonia Edemis' work.

DR. GORDON: I'm sorry?

DR. ORNISH: That is Antonia Edemis' work.

DR. GORDON: No, it is actually not. It is

someone else's work.

DR. ORNISH: Well, she is doing it, too. But I agree with you, I think that should be included.

DR. GORDON: I think it is that kind of approach that we can highlight and then convey as a model.

DR. ORNISH: Thank you. Linnea.

MS. LARSON: Well, that just recalled for me John Dewey's great experiment in Chicago, at the University of Chicago, and that is exactly the model. But there was actually a backlash against that when new immigrants came, et cetera, because it did not teach them the new things that they needed. I think kind of a historical perspective would be important here.

DR. ORNISH: Moving on, and then we will circle back to other things if there is time remaining at the end.

Issue No. 2 is utilization of CAM to help achieve the nation's health promotion and disease prevention goals. Again, I will skip the background and challenges.

I also wanted to mention, by the way, when I

was mentioning Tom Harkin and Arlen Specter, that Dan Burton has also been a real visionary in this area here, too.

No. 67 is "The Commission recommends that DHHS form a working group within the Healthy People Consortium that includes CAM professionals to review the 10 leading health indicators to determine the applicability of CAM to these indicators and, where appropriate, to develop strategies that encourage the use of safe and effective CAM practices in these areas."

Joe.

DR. FINS: I think this is just perfect, the way it is cast within an existing framework and brings CAM into in a substantive, additive way. I think this tone, to me, is something that should be emulated in others when we are trying to get the right balance.

DR. ORNISH: It was intentional to incorporate it into something that is generally accepted as being credible and valid and then by getting a halo effect of that, as well.

Other comments or questions or concerns? Effie.

DR. CHOW: I think this is good, too. I would just like to add CAM principles and practices, add "principles" there.

DR. ORNISH: Okay. Thank you. Other comments? Charlotte, did you have a comment?

Moving on, No. 68, "The Commission recommends that questions on specific CAM usage be included in the national surveys that are the sources of the Healthy People 2010 data."

Comments? Questions? Joe.

DR. FINS: Maybe the leading CAM, not everything, but just like the leading things.

DR. ORNISH: No, we wanted every single thing. Okay, leading it is. Other comments? Questions? Thoughts? Feelings?

DR. PIZZORNO: I wanted to bring up something that was left over from the Access and Delivery, in which we were talking about demonstration projects at community health centers. I think Michele said it was put into this section, but I looked and I didn't see it. It seems like it would probably fit best here, under Issue No. 2. So, I wanted to make sure we don't lose that, because I

think that those community health centers demonstration projects is really important.

DR. ORNISH: Okay. So, you would like to see it here, as well?

DR. PIZZORNO: Well, it got left out of Access and Delivery. It was supposed to moved over here.

DR. ORNISH: Oh, I see.

DR. PIZZORNO: I think this is fine, but I don't see it.

DR. GORDON: Do you want to read it, so we can hear it and talk about it? Is that okay, Dean, if he goes ahead?

DR. ORNISH: I don't know where it is.

DR. GORDON: I'm sorry?

DR. ORNISH: Where is it?

DR. FINS: We had approved it in spirit, but it didn't get into the Access and Delivery piece.

DR. ORNISH: Is it currently in the Access and Delivery?

DR. GORDON: Let's hear it, though, in this context, if there is any more discussion about it.

DR. PIZZORNO: This used to be No. 42, "The

Commission recommends the Secretary of Health and Human Services fund model community-based initiatives through appropriations to appropriate regional offices that integrate CAM and conventional health services, especially in underserved and vulnerable communities. The Commission supports demonstration projects and strategic planning to integrate CAM and conventional health services with emphasis on public and community health. These groups should be funded for at least three years and be required to demonstrate collaborative efforts with local health agencies and qualified community-based providers, both CAM and conventional, and provide quality assurance and evaluation of effectiveness data from the integrated delivery system model. The Commission strongly recommends that such demonstration projects include hospice care, that includes CAM modalities, particularly those utilizing interdisciplinary care teams, that include CP-trained chaplains and qualified CAM providers."

DR. GORDON: It seems to me that that ought to be focused more on wellness. The recommendation for this use is too long. It may work in the other section, but

here there needs to be a more focused recommendation about demonstrations, I think, because wellness and health promotion get lost in that description.

DR. ORNISH: So, Joe, can you do the Cliff Notes version of that and e-mail it to Corinne, and then we will discuss it?

DR. PIZZORNO: I wonder if it should go back to Access and Delivery? I think it should go back to Access and Delivery.

DR. GORDON: I see it as something that can be in both. There is a place for it in Access and Delivery and there is a place for a slightly different version here.

MS. CHANG: My understanding was that those three that Joe mentioned that was missing was going to go back to our group for reconsideration, so we could figure out exactly what happened to them and where they ought to be, and that our group would reconsider those.

DR. ORNISH: Okay. Let's do that. That sounds good. Joe, are you comfortable with that? Okay.

Let's move on. Any other thoughts, feelings, questions, comments?

MS. SCOTT: Just for clarification, the committee, we, are going to consider adding an action recommendation here --

DR. ORNISH: Here where?

MS. SCOTT: Under Issue No. 2.

DR. ORNISH: Okay, which is?

MS. SCOTT: That would speak specifically to a demonstration project at community health centers on prevention and wellness?

MS. AXELROD: We will have to work on that, and it may end up being a separate recommendation.

MS. SCOTT: Oh, yes.

DR. ORNISH: Thank you. Issue No. 3, utilization of CAM in the workplace to increase job satisfaction and productivity and to reduce costs. The Recommendation No. 69, "The Commission recommends that a) CAM be included in all federal worksite wellness and health promotion programs; and b) federal health coverage plans offer a CAM wellness option."

Now, this is deliberately vague, but at least it provides the general intention. Any comments about this, either of these?

DR. GORDON: Did you decide to leave it vague deliberately or is this just a function of --

DR. ORNISH: Well, it was originally going to be much more specific. It is like, either you get it so specific that it is almost a book in itself, or it is so vague that it leaves people enough room to do a variety of different things. We had a hard time coming up with specific examples that were limited.

Corinne, do you want to address that?

MS. AXELROD: Well, even though it is vague, it is a really major policy recommendation, and it doesn't have the specifics in it, but if this actually were to occur, I think it would be a huge accomplishment.

We just say include CAM in all of these programs, without defining what aspect of CAM. This is kind of similar to our discussion on the schools that it is a local decision and that there are federal workers all over the country, in some areas they may be interested in one aspect, in other areas another aspect. It is a consumer-driven movement, and we just want to be responsive to the people that these programs are serving.

DR. GORDON: My response, and then I will yield

the floor to Tieraona, is, it may be too vague. It won't give people an idea of what we are talking about, so I don't think it is going to get much play, because it will just sort of sit there and they will say, oh, well, we have jogging. That is our CAM option.

If it happens, people will just try to fit into it, and they are not going to be inspired by it. I feel that this is, again, one of those opportunities we have to really inspire.

DR. ORNISH: Jim, what would you suggest putting in there? Give me some specific language.

DR. GORDON: I can't necessarily come up with it right now, but I would think of some of the core issues, some of the same kinds of programs, some of the general categories that we talked about with school programs, but I would give some examples, and I would talk about some of the things that we have heard about in worksite wellness programs, programs that integrate relaxation therapies with physical exercise, help people focus on work, or programs that combine dietary change with exploration, you know, Chinese medicine. It could be anything. I think we need some examples. We need

some juice, and that would be the way we could justify it.

I would also say that it is not just about a specific thing. It is so easy to make a CAM option just one thing. We need to talk about some kind of integrative approach to enhancing wellness and self-care and give some specific examples of how that might happen.

DR. ORNISH: Thank you. Tieraona.

DR. LOW DOG: I would just second that, but I think the other thing is, not only is it kind of vague, but if I just read it, CAM be included in all federal worksite wellness and health promotion programs.

So we are going to offer imagery, iridology, bioelectromagnetics. I mean, you just go through the list. It is just too vague. If I saw it, I would just go, eh, because it is beneficial to offer a number of these services and components in the workplace, we think, but nutrition, exercise, stress management, I am not so sure it is so different than what we are offering in the school. We are just big kids.

DR. ORNISH: I think there is some merit to that, both in terms of making it understandable and also

making it more mainstream and assuaging any fears that might be had, that we are not talking about iridology or pyramidology in the workplace. We are talking about things that are more generally accepted. We can certainly change that.

DR. LOW DOG: The place where this dovetails with one of the earlier committees that were talking about demonstration projects to actually show does it reduce absenteeism, tying in -- was it George?

DR. ORNISH: Well, there are a number of worksite wellness programs that have been shown to decrease absenteeism, reduce health care costs, increase productivity.

DR. LOW DOG: Did we quote those?

DR. ORNISH: No.

MS. AXELROD: Yes, actually, they are in the background materials.

DR. ORNISH: They are in the background, but they are not in recommendations, so I think we could flesh that out a little more.

MS. AXELROD: And I think it is an issue that we are just going to have to look at, because a lot of

the information that you have been asking for has been in the background material, and we will just have to look at how much of that we want to actually put in all the recommendations without being too redundant and wordy, but with giving it a little bit more -- sorry -- meat.

DR. ORNISH: All right. Tom.

MR. CHAPPELL: I think this group of recommendations, No. 69, 70, and whatever, could add a search of successful models in order to publish the cost-benefit ratio or relationship here of better health, better savings to the employer.

DR. ORNISH: Okay. Good idea. Effie.

DR. CHOW: I think the discussion about what does it mean by CAM, and we have gone into this for various different recommendations, and I would like to refer back then, as a recommendation, that we really take a look in our first guiding principles and the chart that we said that common CAM therapies and systems of medicines, we listed a bunch of things here, maybe we could still look at that further and then add some others that are not listed there, then, as a point of reference, that when we refer to CAM that they could be selected

from this listing. This is on page 2, in the very beginning of the folder there.

I would recommend taking a real look at that, so that we don't get into every one, so as a part of the document that they can refer back to.

DR. ORNISH: Thank you. Other comments?

SISTER KERR: Dean, how does it fit in, if we should federalize, and most of these recommendations go to DHHS, would we still be wanting to say DHHS or would we want to say and the federal center, if there was one, just to look down the road?

DR. ORNISH: Well, we could say DHHS and other possible organizations. I think it is not going to be any time soon we are going to see an office CAM or Department of CAM, I don't think we are going to see that. I am not even sure that we would need to see that by definition if we are trying to integrate something, as opposed to creating something separate.

Corinne, you probably know more about this than I do.

MS. AXELROD: Well, I think tomorrow, Don is going to discuss, Charlotte, that issue in more detail

about if there is a CAM office where it would be located, and one possibility would be in DHHS. So, even if we say DHHS, it would be up to the Secretary to then assign it, and that is a normal procedure.

DR. ORNISH: Are there any comments on No. 70? We have kind of considered them together, de facto, here. Any specific comments on No. 70 that we haven't heard already?

DR. GORDON: I like No. 70. If we can be more specific about No. 69, No. 70 will fall very naturally from it.

DR. ORNISH: Great. Issue No. 4, "Research on the role of CAM in promoting more optimal states of health and well-being and enhanced quality of life." This is the section we were going to be talking about things I mentioned when I first started, about illness as a catalyst for transformation, about the difference between healing and curing, how many spiritual traditions would take enlightenment as one end of the spectrum, not just the absence of disease. There are a lot of things that we planned to put in here that we really didn't have time to sort out beforehand.

If you have any thoughts that you would like to have included in this section that we haven't already discussed, this would be a good time to make them known.

Oh, I'm sorry, the research workgroup is addressing this issue. I am in that one, too.

DR. GORDON: Is this being addressed in the research group, because I am not sure that I heard the discussion yesterday about optimal states of health. I don't think I did.

DR. ORNISH: Well, I think you could make a case that it could be here also. It went into the research workgroup when we were thinking of not having a separate chapter. Now that we are going to have a separate chapter, we could easily put it back here or have it in both places, or we could have it in the research workgroup and expand more on it here.

MS. POLLEN: I would just like to add something to that. It is mentioned in the background of the research material in terms of emerging areas of science and wellness, separate from disease, so that the was going to be taken and further developed. It could be to some extent in research and also in wellness.

DR. GORDON: Dean, what would you like to hear from us at this point about this?

DR. ORNISH: Well, the background can stay in the research thing, but I think we also can expand on it more here. I think this is where it really belongs. I guess I am just interested to know are there specific themes, ideas, concepts, philosophies that we haven't already discussed that you want to include in here? If you do, you could either e-mail them to us or you could say something about it now, or both. Jim.

DR. GORDON: I think the one that you mentioned is the one that really breaks the new ground, the idea of transformation and the idea of transformation through illness. Also, the other side of that is how about addressing the use of self-care, wellness, and health promotion as a means of changing consciousness. How do people feel about that, about including that in here, because that is the other one that naturally comes up?

DR. ORNISH: Consciousness is one of those words that is a red flag for a lot of people, for whatever reason. Again, I am not saying it should be or shouldn't be, but it just is. But transformation is not,

at least in my experience. Maybe people have different ones. Linnea.

MS. LARSON: I wanted to make a comment on that. When you get into the area of consciousness studies, you get the neuroscience, you get the cognitive scientists under neuroscience, you have the semeiotics, I mean, you have a huge world that I don't think that we have the -- we don't have it. But the general category of transformation might be quite useful.

DR. ORNISH: Thanks. Mr. Chairman.

DR. GORDON: There is another principle that comes in here, which is not necessarily one that we have articulated as one of our 10, is that in most traditional systems of healing that I know about, the function of the particular medical care, of the health care, the highest aspect of the health care is really helping people live in harmony with themselves and with the natural and the spiritual worlds. So, in a sense, this takes us back to our roots in traditional healing, and it takes us back to aspects of our general principles. I think it might be a place that we would want to talk about in a way that people could understand and that would be enlightening

rather than alienating for people.

DR. ORNISH: Thank you. We will try to get something to you between now and the next meeting.

Issue No. 5 is "Incorporation of CAM wellness activities in conventional health care systems to improve health outcomes and to decrease costs." There are a number of recommendations here. Why don't we just start with the first one, which is No. 71, "The Commission recommends that the Department of Health and Human Services, in consultation with the American Academy of Pediatrics, the American Academy of Family Physicians, the National Association of Community Health Centers, and others, including CAM professionals and consumers, develop guidelines and provide training and information on CAM and wellness to clinicians in federally-funded health programs, such as community and migrant health centers, maternal and child health programs, school health programs that provide clinical services to children and their families."

Basically, the other recommendations just say the same thing but to other groups. Why don't we just start with the first one, with No. 71? Any comments or

questions about that?

DR. FINS: General comment here, this is to develop programs and everything, but a related part of this, which may go in the regulation piece is to work with groups like -- we talked about it before -- JACO, you mentioned NCQA down here in No. 76, but also for regulation, the accreditation, the standardization of organizations of health care, hospitals, clinics, et cetera. So, that is a slightly different take, but I think we need to put that on the list as a corollary to this.

DR. ORNISH: That is actually part of No. 72, as well, if you are talking about hospital association and others.

MS. AXELROD: Joe, just for clarification, you are suggesting that CAM programs become a part of like the JACO and other accreditation processes?

DR. FINS: I think we are kind of hovering around it here. This is really to develop programs and work collaboratively in wellness. What I am saying is that there is a role for many of these organizations to evaluate, accredit, standardize the provision of those

services.

Maybe it is a thing for Saturday, or maybe it just gets put into the Access and Delivery part, which is about regulation. We are regulating individual practitioners, but we have nothing on regulation of organizations. So, maybe we just bookmark that for Saturday, regulation of organizations providing CAM-related services.

DR. ORNISH: What do you mean by "regulation"? I don't understand.

DR. FINS: Like JACO would accredit a hospital, and often as a proxy, for a state department of health to say that hospital is accredited.

So, if the hospital is providing CAM-related services, do those organizations have the skill set or the range of expertise, et cetera, or can they regulate herbals or supplements that are in the formulary, those kinds of issues, which we haven't really addressed at all.

MS. AXELROD: Since this is related to wellness, that may be more appropriate for the Access section.

DR. FINS: I was saying that, but I just triggered that thought.

MR. DEVRIES: A quick comment, we might want to look through the different aspects of the Report, because it is a fair comment, Joe. For example, on the regulatory side for health plans, the Department of Insurance and Department of Managed Health Care across the country, they are basically not just looking at benefits and how they are structured and exclusions and limitations, they are looking at quality of management systems and how you basically build your quality management, utilization management systems. So they are very much integrated in the actual delivery of CAM. Trust me, they regulate it and scrutinize it very, very carefully.

DR. FINS: I think we have to address this organizational regulation piece in a systematic way.

DR. ORNISH: Jim.

DR. GORDON: A question I have here is we say DHHS, but this is really about CAM central, in a sense, or this could be about CAM central. So, in a sense, these are some of the functions that CAM central might

serve. DHHS is unlikely to do this itself without some kind of specific entity, it is a lot of work that we are prescribing here.

DR. ORNISH: Well, we are only suggesting that it would be within DHHS. We could certainly make that more explicit, if you would like.

DR. GORDON: All I was thinking is that structurally this might better go eventually as part of the CAM central description or part of our mandate for CAM central, rather than under the wellness and health promotion section.

DR. ORNISH: Good. Did you want to say something?

MR. CHAPPELL: I am thinking all of these recommendations are recommending that the department, and a department is not generative. We need to make a recommendation. It is either Jim's idea, or that we recommend that the Secretary or his designate -- I mean, we have got to have an entity that is generative, that is action oriented.

DR. ORNISH: I think that DHHS certainly implies the Secretary. I don't think the building itself

is going to do anything, if that is what you mean.

MR. CHAPPELL: Well, if we look at some of the other recommendations, it has been more specific to a particular agency. It is kind of flat for me that we recommend the Department. I might just be overly sensitive to it, but I think there are some moments when we can elevate the recommendation to suggest the Secretary.

DR. ORNISH: Well, which agency in particular would you like to see highlighted for these specific recommendations?

MR. CHAPPELL: I am talking about "The Commission recommends that the Secretary or his designate of the DHHS." Do you understand?

DR. ORNISH: I understand what you are saying. Okay. I am not sure that I understand the distinction, but if it is important, we can certainly change that.

MR. CHAPPELL: It is just creating a more generative sense of the action of the recommendation.

DR. ORNISH: Okay. Got it. Thanks.

DR. GORDON: I'm sorry, Tom, I didn't hear the last thing you said.

DR. ORNISH: He said it is more generative. In other words, it looks like there is a real person that we are asking to do something, as opposed to a faceless bureaucracy that we are asking to do something. Is that what you are saying?

MR. CHAPPELL: Yes.

DR. BERNIER: In a nice way.

DR. ORNISH: He said it in a nicer way. I am still learning how to do that.

DR. GROFT: Dean, actually with the Report going to the Secretary and through the Secretary, I think it would have a greater impact upon the Secretary if you designate that this activity that he look at or she look at, whoever it may be at the time, so it is a point well taken. It would be worthwhile to point it at the Secretary.

DR. ORNISH: Thank you.

MS. AXELROD: I would just like to address Jim's comment about putting this all in CAM central. In some cases that may be appropriate, in other cases it may not. Just as an example, if you look at No. 74, that may be more appropriate for the Secretary to delegate to the

Administration on Aging.

Some of these others may be more appropriate to delegate to HRSA, for example. If there is a central office, its primary function would be to coordinate and make sure these efforts happen. In some cases they may actually be doing this, in other cases they may be delegated to an agency that actually has an infrastructure in place.

So, I don't know that we want to tie ourselves to that at this time.

DR. ORNISH: I guess a larger question is, are we making too many recommendations here. Is it better to be more selective?

I am really not taking a point of view on this, but I am just raising it as an issue, because sometimes if you say the Secretary should do this, the Secretary should do this, he might just look at it and go, wow, that is too much, I can't do any of that. Or, he may look at it and say, well, I could do this, but not that. There are two schools of thought on that.

David.

DR. BRESLER: I think there are some learning

opportunities here that we might want to consider taking advantage of. When you look at No. 72, for example, dealing with hospitals, which are the bastions of disease care, I don't know that they understand the difference between illness and disease and that people with a serious disease can have minimal illness and a lot of wellness.

I think sometimes directing them to our guiding principles and saying how some of the guiding principles could fit into maternity units or emergency rooms or so forth, I am just wondering if we should go a little further in taking advantage of an educational opportunity to show how some of the principles, some of the modalities, and so forth can be integrated and some of the potential value of them for those constituencies.

I like the idea we are doing more specific recommendations, but let's even take them out a little further and with more specificity.

DR. ORNISH: Thank you. Joe.

DR. PIZZORNO: Actually, this is a question I wanted to ask Steve, because I have been becoming concerned about the large number of recommendations. Is

there an optimal number of recommendations, kind of a range, we should be aiming for? I think if we have too many recommendations, then it is prioritized.

DR. GROFT: I think it is best to just continue the way we are going with listing out the recommendations, get the number, whatever we have right now, and as we go through the editing process, we will reduce them even more. You will see that some really aren't as significant as others and that we might want to reduce and not do a recommendation, eliminate that as a recommendation and just put it into text.

So, I think just go the way we are going now, and I think when ever you do your carvings, you start with something huge and you keep shaping it. I think that is what we have to do, and I think that is what the groups will do as we continue.

So, I am not worried, but I would think somewhere in the 40, 50 range. Again, it is really what do we need to have an effective report, I think, to keep that in mind. If they are solid recommendations, well thought out and well directed, it is a good recommendation.

DR. ORNISH: Thank you, Steve, for that recommendation.

MS. SCOTT: Steve, clarification. Do you think, then, it would be helpful for those of us in our workgroups to try to attempt to say this would be our priority?

DR. GROFT: Yes. I think we definitely want to do that in the future.

MS. SCOTT: Because I think it helps, if that is where you are going with it, and there is going to be some cut-down. I think maybe in our groups we might want to say, well, we feel very strongly that this is, and maybe less strongly.

DR. GROFT: We actually started in the discussions with the workgroups to try to have you prioritize.

MS. SCOTT: I know. We resisted it.

DR. GROFT: But you can't do it yet. It is really premature. I think to proceed is the way to go, and then do it later on.

MS. SCOTT: Okay. Thanks.

DR. GROFT: Plus, we don't want to give the