wrong message out that what is a priority today may not be a priority in December, as different things evolve and we become aware of new information.

DR. ORNISH: Thanks, Julia.

We need to move on. Isn't Jim going to do a summary at the end?

MS. AXELROD: Jim actually ceded you 15 minutes, so you have got about 12 minutes left.

DR. ORNISH: That gives us about two minutes per recommendation, so we should move forward.

No. 72 is: "The Commission recommends that DHHS, in consultation with the American Hospital Association and others, including CAM professionals and consumers, identify strategies to incorporate CAM in wellness, prevention, and self-care in the nation's hospitals."

DR. WARREN: Shouldn't this be more in long-term care or rehabilitative care facilities, instead of hospitals?

DR. ORNISH: Well, we see it in both, actually, and hospitals includes both. But if you want to say in hospitals and long-term care facilities, we can certainly

add that.

DR. WARREN: I like that.

DR. ORNISH: Okay.

SISTER KERR: Acute care and multi-level care.

DR. WARREN: How much wellness can you talk to somebody in acute care?

DR. ORNISH: A lot, actually.

DR. WARREN: Can you?

DR. ORNISH: Yes.

DR. WARREN: I thought it was more like keep them alive.

DR. ORNISH: Not necessarily.

SISTER KERR: What David was saying, I thought that was a great statement.

DR. BRESLER: For your committee to consider the possibility of looking at this as an educational opportunity to give them specific ways in which our core principles and some of the other things we have discussed could be of great use to these various constituencies. Just to say that we should work with them and develop strategies and plans, it is not going to go anywhere.

DR. ORNISH: Do you have any specific examples

you would like to include?

DR. BRESLER: I could go on and on and on. Pain management, for example, which is my particular area, is an extraordinary opportunity for there to be an integration of high technology and ultra-high technology with a lot of the basic core principles that we have talked about in CAM. And there is not a hospital that shouldn't have a pain control facility, just like an emergency room or an intensive care unit and so forth. But I am saying that the constituencies who are going to be looking at this report don't understand this. To keep it very generic is not going to excite them or motivate them and so forth.

I think the educational opportunity is to show them by example, for example, ways in which the things that we are talking about can enhance their activities, can be integrated into their activities, and provide better care to their constituents.

DR. ORNISH: So, you are really saying that you would like to see at least one or two specific examples under each one of these recommendations, as a way of orienting the thinking.

DR. BRESLER: Yes, and I don't know whether you want to bite off in the wellness section this distinction between disease and illness.

DR. ORNISH: That is going to go in the section, Issue No. 4. Other comments?

No. 73 -- did I miss someone?

MS. AXELROD: No, on No. 73.

DR. ORNISH: What is it?

SISTER KERR: Just a wording, when we get to the last sentence, including CAM professionals, et cetera, wellness prevention, self-care activities and continuing education for, and then you have the litany of physicians, pharmacists, nurse practitioners, either we should get a word, words that include everybody, for example, a sensitivity thing could be nurse practitioners, though I studied as a nurse practitioner, we ought to just say nurses. It is not just nurse practitioners, there are many nurses who should be included. But I wonder if we should just say health care professionals, caregivers. Professionals excludes people, too. What is the right word?

DR. ORNISH: We are being too specific, you

mean?

DR. BRESLER: You are not even including mental health professionals on the list.

DR. ORNISH: That is the problem when you start getting specific, you see. That is a dilemma that we face, once you start to make a list, then you start offending people by excluding them, whether it is a list of practitioners or a list of concepts or modalities. So we are getting both sides of this. Joe.

DR. FINS: Structurally, whether it belongs in the education section or not, where a lot of groups are mentioned by name.

DR. ORNISH: That was the whole point is that almost any one of these recommendations could also go in another section. That was the whole reason why we were debating at the beginning whether it should be a separate section or not. So, there is inherently going to be some redundancy here. But we can certainly change nurse practitioners to nurses, I think that is a good point. And mental health professionals.

DR. GORDON: The intent here is basically conventional health and mental health practitioners; is

that right?

DR. ORNISH: Yes.

DR. GORDON: Which is a way to cover the whole genre.

SISTER KERR: Those nurses aides and people that are transporting people through the hospital, who may be the most best primary care person today because they have time to talk to people, so you know.

DR. ORNISH: We will just say, "including physicians, pharmacists, nurses, et cetera, et cetera." That way, we make it clear we are not trying to limit it, we are giving examples, because then you have got the phlebotomist. Where do you draw the line?

MS. AXELROD: I just want to come back to Joe Fins' comment that even though the education group is addressing CMEs that this focus here is on wellness and CMEs have such a strong focus on illness that I am afraid if we don't' make it specific as a wellness activity then that is just not going to happen.

DR. ORNISH: Okay. No. 74, any comments or questions?

Maybe in the interest of time, why don't we say

Nos. 74, 75, 76, and 77, any comments or questions? Just say which paragraph you are referring to. Joe.

DR. FINS: I think on No. 74, especially given Senator Breaux's hearings recently, we need to talk about incorporating wellness, prevention, self-care, sort of the safety of this. There has been a lot of fraud and taking advantage of that very vulnerable population. So I think we want to appreciate that these entities not just promote but also seek to regulate. Again there is overlap, but I think we have to be careful.

DR. GORDON: I have a reaction to that. May I express my reaction, Dean?

DR. ORNISH: Yes, please. I would invite you to.

DR. GORDON: Thank you. My reaction is we are talking about wellness, we are not talking about somebody saying, I've got the cure for cancer, here. I think we don't have to hedge all the time with wording about fraud. We are basically talking about health promotion.

DR. FINS: I think we may want to be in touch with his office and the strong sentiments that were expressed before his committee regarding how in the

pursuit of wellness a lot of unwellness and disease and abuse was occurring. So, I think we need to be sensitive to that, whether it goes in this particular recommendation or somewhere else in the body of the Report is really immaterial, but I think there is an issue.

DR. ORNISH: Many people don't realize that when we ask DHHS to provide a new service of any kind, or when anyone asks them to provide a new service, it has to go to the Congressional Budget Office, where they score it, and they say, how much money is this going to cost. They almost never score anything as saving money, it is always a cost, it is just a question of how much.

So, even though we don't say, this is going to be paid for by DHHS, by the fact that we are recommending, we are recommending costs. The one issue they are, particularly Medicare, are extremely sensitive to, not just John Breaux, is fraud and abuse. A major they have with any new benefit, which in effect these would be, is the potential for fraud and abuse, even in the name of wellness, it is because of the cost issues more than anything. So, I think it is something we need

to be mindful of.

Tieraona.

DR. LOW DOG: I think fraud issue was important to raise, only because lots of people are targeted with all these supplements and vitamins and things that will make you live to be 150 and that. So, I do think it was appropriate to raise.

But it also raises something else, and maybe it needs to go on tomorrow. I am not sure where, but since we have been talking about wellness and self-care, and about access to vitamins or minerals, or dietary supplements that are not fraudulent but that have shown to be of benefit, such as folic acid, calcium in elder people, things that are not covered by Medicaid, Medicare, that are not often reimbursed under health care systems but that have proven health benefits.

When we talk about access, we talk about wellness. I am not sure where to put it, so I am just throwing it out there. It is something that we haven't really talked about because we keep focusing on services.

DR. GORDON: Don't you think it goes in -- this question is for you -- the issue that you raised earlier,

which is access to products?

DR. LOW DOG: Okay. Yes, because it is part of wellness.

DR. ORNISH: When you think about it, even the prescription drug benefit that both presidential candidates were in favor of is probably never going to pass for many years. So, it is really a very sticky wicket.

I am not saying that we shouldn't make these recommendations, but we should also not kid ourselves about the fact that these are going to cost billions of dollars if we were to do these things.

DR. LOW DOG: Right. Folic acid, I think, for women of childbearing years, I agree, and calcium for especially people at risk for osteoporosis. I'm just throwing it out there because we are talking about including all these other things that are going to cost lots of money. If we are going to dream, might as well dream big.

MR. DEVRIES: It really would qualify under reimbursement and coverage, services or products proven to be clinically safe and effective.

DR. ORNISH: Those are good points.

MR. DEVRIES: Those are good examples.

It is a tough road. I'm not saying it isn't a tough road, but I'm just saying that conceptually we have the right approach.

DR. ORNISH: We have five minutes left, so I want to make sure we have time.

DR. GORDON: We have five minutes. The point I was making about fraud is more that we can't, every time we say something, talk about fraud. I think that when it comes to public information -- and this is not just true of fraud, it is true of many of the issues we have talked about -- we have to someplace make some strong statements, but not continually make the statement, because if you continually make the statement, it is a kind of reflex that doesn't feel like it has authority.

DR. FINS: It was only mentioned, Jim, in the context of the aging population, which was the focus of the Senate Committee on Aging. So, it was really in the context of that particular population.

DR. ORNISH: So, Joe, in the interest of time, what would you like it to say? What would the words be?

DR. FINS: I think it probably goes back into the regulation section. This is about wellness and promoting wellness, that is fine. But if we want to talk about that particular population, I guess the point is is that the promotion of wellness sometimes is not completely innocent.

DR. ORNISH: I understand. I understand the concept. What words would you like to put in there?

DR. FINS: Well, I am not going to wordsmith it right now.

DR. ORNISH: We will take it back to our committee.

DR. GORDON: I think the more general issue is are some of those small additions, which don't need to be made today, necessary. I have heard David speak, a couple of people have spoken about them, in all of these.

So, there may be small modifiers or additions that are appropriate for each of these categories. We talked about JCAH, and I think that people need to look at this, and if you don't come up with them now, to give them back to Dean at a later time and see how they work when they come back to us.

DR. ORNISH: Great. Thank you. We have got three minutes left to cover the remaining four issues. Any other thoughts or comments specific to these that we haven't already discussed?

SISTER KERR: Excuse me, just clarification. The last four issues, meaning these last recommendations?

DR. ORNISH: The last four recommendations, right.

SISTER KERR: And that is the end of our time period? Because I have two new things I want to bring up.

DR. ORNISH: That is the end of our time period. Well, we have got three minutes left, so we have four recommendations to talk about and then you have two new things. It would have been easier to do if you had said something earlier. I don't know what to do, we have only got two minutes. So, how do you want to use the time? New issues tomorrow? Okay.

I just was priding myself on trying to get this done on time.

SISTER KERR: They are not new, they just haven't been isolated. We have already brought up one,

and one we have talked about.

DR. ORNISH: Why don't you say what they are?

SISTER KERR: One is, I wanted to quote a Mr. Larson, who, at least four ways, has spoken to spirituality and health. There is a handbook of health and religion that has 1,200 published studies on religion, spirituality, and mental and physical health outcomes. He reports that 90 percent of Americans describe themselves as religious or spiritual.

Most of conventional science -- this is important -- disregards the effect of these factors on health, and a stigma continues to exist in the research, science, and academic communities around these hypotheses, reflections on CAM.

He has two initiatives: "Develop a centralized database on spirituality and health that contains information on grants and funding on model care and educational programs, and effective strategies for sensitivity and ethically incorporating spirituality in health care."

Second was: "Supporting continuing education conferences and other education materials to help make

clinical and research communities better aware of research linking spiritual and religious factors to aspects of health."

I would like to end that statement and say the other point I wanted to make, No. 2, in light of something Tom brought up is that we should consider a communication campaign that would both educate and promote wellness from the perspective and the principles of CAM.

DR. LOW DOG: Charlotte, we put up spirituality and wellness as a topic for tomorrow. Is that okay?

SISTER KERR: Yes.

DR. GORDON: I knew it sounded familiar. This was part of the earlier wellness report.

DR. ORNISH: And it will be part of Issue No. 4 that we are going to be elaborating on.

DR. GORDON: I think there are two ways that this can be considered. One is time-permitting tomorrow. In any case, I think this also comes under Issue No. 4 that we have here. So thank you. We can deal with it there, as well.

DR. ORNISH: Other comments or questions?

Thank you, Charlotte.

I was considering Nos. 74 through 77. I was asking for comments.

DR. GORDON: I would just like to add, and this is something to come back to later to think about, is in No. 77. I think that is an appropriate place for us to get more specific, perhaps for us to give more specific recommendations. I think it is very interesting. It is a great recommendation. I think that it is one of those times where we can really take an initiative and look at a little bit more closely at the kinds of things we might suggest.

DR. ORNISH: I also want to reiterate, Charlotte, to your point about spirituality, that spirituality and religion, the health benefits will be part of Issue No. 4, and we will be careful to make it clear that the state is not mandating specific religions or one as more healthful than another or even religion versus spirituality, but these will be discussed in that topic, because we all feel very strongly that they are important.

DR. GORDON: We are out of time, and then some.

Thirty seconds.

DR. FINS: Bereavement services, as well.

DR. ORNISH: Bereavement what?

DR. FINS: Bereavement, dealing with losses, as a component of wellness, needs to, I think, be put into this educational program.

DR. ORNISH: Okay. Jim, would you like to summarize?

DR. GORDON: Yes.

MS. AXELROD: Are you referring to No. 75?

DR. FINS: It could nicely be incorporated into that. Of course, the loss that we are experiencing collectively, that, I think is especially applicable.

DR. GORDON: I also think it might fit into the spirituality section, as well.

Let me recap. Actually, this was a quite wonderful discussion, because one of the things that we really did here, I feel, is to expand. We came to a very clear sense that wellness needed to be a separate topic and that it needed to be integrated into the other sections.

We then went on to very much look to allow

ourselves to envision the impact of wellness and some of the dimensions. So, I feel like we did some collective work here and used our imaginations. It first came in No. 64, where there was a strong sense that we both needed to be more specific in terms of focusing on issues like stress management, food, exercise, et cetera.

On the one hand there was a specificity that was important. On the other hand, there was an understanding that Tom initially brought up, and I felt a certain consensus around, that this needed to be a major initiative, and in a very high profile way. Exactly how that CAM-paign -- and I love that pun -- that campaign would be created is up for grabs.

Tom, I hope you will work with Dean on this, because I think it is really important for you to use those skills to do that.

On the other hand, it was very interesting that there is a kind of interplay between a federal campaign and local initiatives and what is going on locally, and that that connection seems very powerful.

No. 65 followed. Once No. 64 is in shape, it looked like No. 65 would follow very naturally from No.

64.

No. 66, there was both an emphasis and on what should and what should not be in the schools, and that was a change. We need to find exactly the right wording for it, the group does.

Nos. 67 and 68 essentially were agreed on, as is.

No. 69. Again, there was an interest in having some more specificity about the kinds of programs, and with an emphasis on -- although Dean thought at first pyramidology should be included, he decided on reflection that perhaps not --

DR. ORNISH: Iridology, not pyramidology.

DR. GORDON: Iridology, okay. So, there is a sense of we are not talking about just throwing a technique here or a technique there, what we are really talking about is a kind of integrated approach and understanding that there are going to be many different ways that this is going to be adopted in different communities and that, indeed, there may be some communities that are interested in one approach or another, and that may integrate this. We are not being

prescriptive here, but we are being descriptive of the kind of dimensions that we are looking at.

No. 70. My understanding was that passed pretty much as is, and that, again, we may want a little more specificity if we can give some here. If we can't, then the recommendation would stand the way it is.

Nos. 71 through No. 77. My sense was that there may be specific additions to each of those, and we heard a couple, Joe's concern, particularly with issues related to fraud or the other side of it could be education to help the elderly take better care of themselves. There are issues related to Joint Commission on Accreditation of Hospitals, that all of these could perhaps use some specific suggestions, and it was suggested that those who had some specific suggestions give them in to the committee so that they could be included in the next iteration.

DR. ORNISH: And also you skipped over Issue No. 4 and Charlotte's recommendation on the spirituality, which were important, will be included in that section.

DR. GORDON: Right. Thank you. And then also in Issue No. 4 there was a general sense that

transformation is a quality and a characteristic and a dynamic that should be discussed, both transformation in terms of coping with illness as an opportunity for transformation and also transformation as an aspect of health promotion and wellness.

DR. ORNISH: Great. Good summary.

DR. GORDON: Thank you very much.

DR. ORNISH: Thank you. I appreciate the opportunity.

[Applause.]

DR. GORDON: Just a couple of announcements. We will have about a 20-minute break. We will come back promptly at 4:15.

[Pause.]

DR. GORDON: We will take a 15-minute break. We will come back at 4:10. We do have to be out at 5:00 promptly.

Tomorrow morning there will be, after the discussion about the possibility of a creation of a CAM central office, there will be an opportunity for us to talk about our experience of the events of September 11th as a group, then we will go on to new issues.

Let's adjourn until 10 after 4:00, and then we will come back at that time.

[Recess.]

Public Comments Session

DR. GORDON: We are now moving into the public comments section, and I see some wonderful and familiar faces.

We are going to give three minutes per person, and then, after each panel speaks, there will be an opportunity for the commissioners to ask questions.

Let's begin with Dannion Brinkley.

MR. BRINKLEY: Thank you. Thank you very much. I have been a part of the ongoing process now for 13 years. This Interim Report is absolutely wonderful, and I am watching this come together. If someone just read this information and looked at the recommendations and the testimony, they may not see as much cohesiveness as there really is, but anyone who is so interested, comes and sees the interactions of the personalities. You all have titles, but you are really human beings, and you are really spiritual human beings.

I am very, very proud to see the human spirit

being involved, and the personalities of the people is what will really make this work.

As I watched the recommendations, knowing that I have been around for a long time, I see the potential of a real transformation. September the 11th caused a transformation in our society, and that society cannot be healed, a lot of times, by conventional medical practitioners. It will have to be CAM.

You can't take a small child, who is afraid now and frightened, and drug that child into security and comfort. It will take classroom agendas, it will take meditation, it will take calming methodologies, it will take qigong, energy medicines, to really bring a harmony and balance back into this society.

Yesterday in the "USA Today," it was: "American Workers Rethink Their Priorities." This is really telling us that we are on schedule, these recommendations are on schedule. I can't help what 9/11 meant to us as a people, but what it meant to us as a world and what I saw on the days after the event that happened was what I want America to always be.

We saw every complementary therapy and every

conventional therapy at work in New York City and in Washington, D.C. We saw it and the world saw it.

What I would like to do is thank you guys. Mind, body, and spirit, not spirituality -- it will evolve to that -- but mind, body, spirit, what drives this country, what makes it great is our ability to pull together, find the greatest methods and ways of doing it, and achieving it, and creating wellness. We have the spirit of the Americas. We have the spirit of our own religious perspectives and the spirit of our medical identities.

I am proud, and I am really proud of you. The interaction of the personalities shows that we not only can make this happen, but that we are making it happen. I think that you are contributing immensely to wellness.

I want to read one thing from today's "The Hill" magazine. "Echo of terrorist attack jangle nerves on Hill." [Sen.] "Carper speaks of his fear for his employees and mentions reccurring nightmares, bouts of sleeplessness, and the inability to return to some kind of a normal life."

One of the recommendations is that all federal

programs incorporate a CAM modality. You can easily mask this with drugs, but the long-term care to bring that about is the CAM perspective. It is now in front of us. We must seize the day.

Once again, bereavement is a very active part in the course of where we want to go. I deal with end-of-life care, and I watch a lot of the techniques and modalities that you speak of work at the end of life. If it works there and we focus a part of what we do in end-of-life care recommendations, we can back-engineer the whole medical profession.

Thank you, and I'm proud of you.

DR. GORDON: Thank you, Dannion. Boyd Landry.

MR. LANDRY: Mr. Chairman and members of the Commission, my name is Boyd Landry, and this is probably the fourth or fifth time that I sit here before you.

Now is probably the most important opportunity that I may have to give some particular insight into what it is that you have put forth in the context of the Interim Report and the draft recommendations. It may sound a little bit stern. I may sound a little bit upset, but please bear with me as we move through this

process. I would like to make a few general comments about the Report as a whole and then make a few specific comments about certain statements and sections in the Report.

The Report fails to respect the rights and wishes of consumers, as it is consumers who are driving this train. In addition, the Report fails to respect the unregulated practitioners who provide billions of dollars of service to consumers.

Finally, the Report fails to respect the importance of the Minnesota Health Freedom Law passed last year. The Report does not even mention it, yet the Report devotes a whole paragraph to the regulatory status of CAM practitioners. Failing to commend or even make reference to the Minnesota Health Freedom Law is very ironic, given that the Commission devoted a significant amount of time and money to host a town hall meeting in Minnesota.

Under Section A, "Overview of CAM," in the first paragraph, the second sentence that starts with "among" and ends with "United States," during the four town hall meetings the Commission has hosted and the

seven official Commission meetings, an enormous amount of testimony has been given, which distinguishes the practical and philosophical differences between traditional, naturopathy, and naturopathic medicine. Yet, this section of the Report treats them as though they are synonymous.

Out of respect for the people who have successfully distinguished the two in testimony before the Commission, I would implore you to refrain from using terms that could perpetuate misinformation and cause confusion for the readers of the Report.

In the section on page 4, "Commission's Progress To Date," the first paragraph, first sentence that starts with "the Commission" and ends with "where appropriate," it was not my observation that the majority of those who provided testimony at these hearings believed that the complete integration of CAM and conventional medicine is advisable.

It is certainly not the opinion of the Coalition and its members. It is our opinion that the diagnose-and-treat-disease based approach of conventional Western medicine is largely incompatible with the

holistic wellness-based principles of CAM.

A majority of practicing allopathic physicians in this country will need to undergo a complete transformation of their approach to health in order to effectively integrate CAM therapies into their practices. Until that transformation occurs, discussion of integration is pointless and premature.

The second sentence of that paragraph starts with "furthermore" and ends with "research." The use of the word qualified as an adjective for CAM practitioners suggests that the government should have a role in determining who is qualified rather than letting the market forces, driven by consumers, determine which practitioners stay in business or not.

[Interruption.]

MR. LANDRY: Is that time, or is that one minute? Okay.

This is not the role of government. Wow, that went pretty quick.

I will remind the Commission that my organization exists to promote and protect natural health freedoms, and it is because of our mission that I find it

extremely egregious that no mention was made anywhere in the report of the Minnesota Complementary and Alternative Health Freedom Act, which both protects consumers and practitioners, and renders moot most of the arguments for licensure, certification, and registration. Thank you.

DR. GORDON: Thank you. And thank you for your attendance and your thoughtful critiques.

Harry Swope.

DR. SWOPE: I am Dr. Harry Swope, a naturopathic physician, licensed in the State of Arizona. I am also Vice President of the National Center for Homeopathy and President of the Council for Homeopathic Certification.

Since certification is one of your key concerns, I am here to address to you today a model which I believe illustrates how self-regulation can be applied to CAM practices. Practitioners of homeopathy in North America have successfully addressed the issue of creating uniform standards of education, training, and certification. Ten years ago, the community of professional homeopathic practitioners undertook this self-regulation to ensure the public could have access to

safe and effective homeopathic care.

Homeopathy is a 200-year-old healing art with a distinguished record of safety and effectiveness for both acute and chronic illnesses. Today's practitioners are a diverse community from a wide variety of medical and non-medical backgrounds. In 1991, the Council for Homeopathic Certification drew together recognized leaders within the homeopathic community. Since that time, the CHC has worked with representatives of other homeopathic organizations to create standards that serve the profession and the public by creating a standard of training and competence for the professional practice of homeopathy, defining standards of homeopathic care and professional ethics, administering a rigorous examination process to certify homeopaths to this level of competence, fostering excellence in classical homeopathic training and practice, and assisting the public to choose appropriately qualified homeopaths by providing a national directory of certified practitioners at www.homeopathicdirectory.com.

The certification process is administered by a board of directors that includes homeopaths from major

health care professions and from the growing group of non-licensed professional homeopaths.

Drawing on certification and licensing methodologies for all the major health care professions, the CHC established criteria that were appropriate to the practice of homeopathy across a wide variety of health care settings.

Because this process was developed by prominent practitioners within the profession and because it encompasses training and ethical behavior, as well as therapeutic competency, and because it is applicable to the wide variety of health care settings that the public has come to demand, we think the CHC has created a viable model for promoting uniform standards of competence for CAM practitioners.

Therefore we recommend that the Commission endorse the concept that each CAM profession adopt its own rigorous standards, provided that the standards ensure adequate protection of the public.

Thank you.

DR. GORDON: Thank you very much.

Len Wisneski.

DR. WISNESKI: I would like to thank the commissioners and the Commission for the hard work and diligence that you have done thus far and that you will be doing in the future.

I am Len Wisneski, founding Co-chair of the Deisn Principles for the Health Care Renewal Working Group, which was formed during the Integrative Medicine Industry Research Summit in May of 2000. Our group presented its findings to the Summit in May of 2001.

I have been personally drawn to this work due to the absence of clearly articulated guiding principles in either my medical education or in my subsequent training. Core principles drive the way health care operates and is experienced. Times of change and disturbance cause to examine, clarify, and commit to renew our individual and community practices.

Our charge is to reconnect with core, shared values based on missions, visions, and principles of diverse stakeholders. This represents an initial effort to create a unifying view of a renewed system for health care delivery. Many health care organizations have found that connected with principle is what allows excellent

work to be engaged.

Our group has gathered 47 sets of principles from professional associations and organizations, as well as from traditional, culturally-based health care systems. We then developed a draft set of design principles from these 47 organizations, and I stress the word "draft." These are not platitudes, they are practical. These are design principles to help us shape the integration process.

Distribution of health care resources and health care policies should follow the principles. The principles underscore that the Commission's work is not about grafting a collection of therapies on to what we now have. Integration is about a much broader and deeper values-driven process in American health care and in the American culture.

Secondly, representatives of diverse stakeholder organizations at the Industry Leadership Summit agreed that we need to have the establishment of an office for complementary and alternative medicine and integrative health care inside the United States Department of Health and Human Services.

The office would have the authority to oversee, coordinate, and direct federal, CAM, and integrative health care activities, including complementing the NIH NCCAM agenda in such areas as education, policy, health services, outcomes, cost effectiveness, and field research.

From our perspective, if such an office is not established, we will not engage as a people and as policymakers the full breadth of meaning of this integration process which our patients, our voters, our constituents have asked for. Without such an office, we will not embrace the principles which drive the popular movement and drove the creation of this very Commission.

In summary, we recommend that the Commission include a set of the draft principles in its recommendations and recommend the development of consensus integrated principles by diverse CAM, conventional, and public stakeholders. We strongly support the establishment of a federal office on complementary and alternative medicine and integrative health care on behalf of the American public.

Guiding principles and core values are not only

the heart of CAM but the heart of all health and health care practice.

Thank you.

DR. GORDON: Thank you, Len. Thank you for the work that you have done on those design principles.

Questions from commissioners, questions or comments? Tom.

MR. CHAPPELL: Is it Harry Swope?

DR. SWOPE: It is Harry Swope, yes.

MR. CHAPPELL: Thank you. It was very interesting to hear your example. I wonder, have you learned from the failings of other professional groups why self-regulation hasn't worked more effectively for them?

DR. SWOPE: That is a difficult question to answer. I think my personal ethic dictated that I go to naturopathic medical school, four years, get a degree, get a license in order to practice, but I still honor the fact that people who dedicate themselves in an appropriate way to the public safety aspects of practice can do, in particular, homeopathy.

I am not so confident that I would like to have

non-licensed people doing naturopathic care, but homeopathy, because of its inherent safety, because nobody, to my knowledge, has ever been harmed by a homeopathic remedy properly administered.

The key is more, in my mind, making sure that our practitioners understand the public safety aspects, the physiology, the anatomy, the pathology so that not that they can diagnose, not that they can treat as a medical doctor would, but that they are aware of what the issues are, that they aren't silly about it, that they aren't cavalier about it.

This is not a religion. This is health care. This is a public service. It carries a public duty with it. I would think that the people who are not willing to step up to honoring the necessity to protect the public by doing some work, by doing some study, by stepping up the standard, create problems for themselves.

That is why I created, along with some of the other leaders in homeopathy, the Council for Homeopathic Certification, so that among the people out there practicing homeopathy, if I want to refer my mother, as I have, to a homeopath in Maryland, and I am not in

Maryland, I have some way of knowing who is adhering to the standard, because they have stepped up to what we have asked them to do to be certified by our Council.

MR. CHAPPELL: Thank you.

DR. GORDON: Thank you. Other questions or comments?

I wanted to say a couple of things. One is, I wanted to especially thank the three of you whom I have known for some time now and seen before. Especially, I want to thank Dannion for your support and your thoughts and your spirit, and for being with us all the way.

I wanted to say to Boyd Landry that I appreciate your analysis and your persistence. They are very important. And the Minnesota model is important. I was just checking through the Report, and I realized it is not in the Interim Report. It has very much been a part of our thinking and a part of our reflection. Certainly, we will be dealing with it in the Final Report.

I think that we are sensitive -- and we appreciate your thoughts about it -- but we are sensitive to some of the issues of people who are community-based

or traditional practitioners. I hope that our discussion reflects it. As you read over what goes up on the site following this meeting, I would appreciate any further input that you have. I am sure that there are some differences of opinion between various ones of us and you, but I also think that your voice is crucial to helping us understand some of the issues. So I really wanted to thank you for that.

And, Len, I wanted to say that I would like to ask you and others from the group that you are working with to take a look at the principles that we have articulated, which are very much going to guide us. I think that what you will see, what I saw when I was out at your meeting in Arizona, is this tremendous amount of congruence between our principles and many of the principles you have articulated.

The other thing I want to say is that for all of you -- and I appreciate your putting the emphasis on the importance of a creation of an office, we are going to be talking about that tomorrow morning. As you know, our recommendations are only, even though we will have spent close to two years in listening to a thousand

people in person and a couple thousand people, at least, who have communicated with us, our recommendations will only have force if the various communities that are interested mobilize themselves. Clearly, you will be able to see what we say in relationship to having a central office, and we would appreciate any input about that central office. And, remember, if it is going to happen, it is going to depend on very strong public support, support of practitioners and of the general public to make it happen.

I just wanted to share those thoughts with you.

DR. WISNESKI: Jim, I appreciate what you are saying, and I am sure our group would be very pleased to look at the principles that were articulated by the Commission; however, we are not promulgating a set of principles, we are promulgating a process by which all stakeholders can articulate principles which may end up looking somewhat different from what you see in front of you today. That process, when honed and embodied, will help renew, rejuvenate, and redesign the health care delivery system of our country.

DR. GORDON: Great. Thank you. Other

questions or comments? Dannion.

MR. BRINKLEY: I know I get more excited than most of you guys, because you sit and deal with it, but right now the place that I'm focusing in is veterans, and I look at the end-of-life care for veterans. I watch a lot of the therapies you talk about work in veterans at the end of their lives.

We are now looking at a country preparing to go to war or participating in war, every major person that is of any position of power from Colin Powell to a son protecting his father, a World War II veteran, which my father is a disabled World War II veteran who uses this type of stuff because I bring it home from you to him.

Now, when you look at 24,800,000 veterans, you look at the loss of 45,420 per month, and it is a closed system. If we take time to focus on the veteran who is about to go and serve, and look back at those who did serve, you have the opportunity to create the greatest model for conventional and complementary integration into a closed system that can be researched and looked at.

I know the 24.8 million people whose sons are now going to war, whose fathers went to war, and who -- I

am a veteran myself -- are going to look strongly at moving this forward and getting it established as an office of what Len was talking about, and you are the people who can make it happen.

I look at this, we are losing and preparing, and we are all in the middle with our hopes and dreams. I just wanted to make sure that you guys take time to look at the veteran, look at the VA system, and, as you look, instead of generally out in the whole world, look at it in that context and that criteria, because it is all there.

It is a cross-section of all we are, and it is a place where the opportunity avails itself to walk in and create the system. Then move it back out into the general public, because they have already paid for the service. We are trying to bring the best quality of care to them that they have paid for already.

DR. GORDON: Dannion, thank you for the reminder. We heard testimony from the VA, and I think a lot of us share your feelings. Any concrete suggestions, if you want to write out -- because part of what I think you heard today is, in some of our recommendations we are

trying to make them more concrete -- any thoughts, specific thoughts, you have about the VA, we would really appreciate getting, because I agree with you, that is one of the areas where we can really, perhaps, make a difference.

MR. BRINKLEY: It is going to make the political side pay attention. It is going to make politics pay attention that we are not a bunch of people just sitting here trying to do something whimsical. It is going to show that if a World War II veteran who spent time in a German prison camp, and I can use aromatherapy and color therapy on him -- and it may be a little anecdotal -- but he leaves this world in peace and in comfort.

There is a viable position that we can take in the political arena that makes this stuff move forward, and that moves some academia and medicine into the political force, and then out into the public, because supposedly we are going to take care of those who stand up and defend us.

Thank you.

DR. GORDON: Thank you. Thank you all.

[Applause.]

MS. CHANG: Thank you. If the last three would come up now. Daniel Benor, David Molony, and Susan Delaney. Thank you.

DR. GORDON: Welcome, Dan Benor.

DR. BENOR: Thank you. Thank you, Jim, and thank you very much for the opportunity to address this august group, whose work is truly impressive.

I am here to share with you a little bit about spiritual healing, as in Reiki, therapeutic touch, prayer. Not knowing most of you, I would just like a show of hands, how many are familiar with Reiki or therapeutic touch or this sort of treatment.

Good. So I am not talking from point zero.

I have, as a physician and psychiatrist, been very skeptical about this when I first started looking at it. It has been a process of about 20 years of exploring healing, to the point where I am absolutely convinced that it does work.

I have managed to get my publisher to agree to give you copies -- if you haven't received your copy, they are out in the lobby -- of "Review of 191 Controlled

Studies of Healing," showing that it is a potent intervention. It can have effects in humans, animals, plants, bacteria, yeasts, enzymes. So that there is really no question that it is an effective, potent intervention.

Healing, as in mental intent, as in prayer, works. Our prayers do have effects in the real world, not just hopeful effects, wishful effects, placebo effects, but actual effects on physical illness, not just in humans, but in animals and plants. This is not a placebo. This really does work.

I have been blessed to be able to work with a group of people, the Council for Healing. We are bringing together the collected awareness, knowledge, experience of people who have studied therapeutic touch, healing touch, qigong, Reiki, other forms of healing, so that we can work together and learn together how healing can be most effective as an integrative component in our health care.

We are not interested in promoting this as an alternative, we feel that that is a very divisive term, although it is the most term that people have used. We

would like this to be an integrative component of health care. We would like to see this introduced more and more in nursing schools and medical schools, and we are hoping that the work of this Commission can make that more and more possible.

Thank you for the opportunity of speaking here. I have given a handout that includes the list of the people participating and contact information and some of our ideas on ways forward in research. We know that healing does work, our next question is how does it work. Thank you.

DR. GORDON: Thank you. And thank you, Dan, for all your wonderful work. Susan Delaney.

DR. DELANEY: Thank you. My name is Dr. Susan Delaney. I am a naturopathic physician from the great state of North Carolina, basketball country. I work with the University of North Carolina as one of the five CAM centers that received an NIH grant.

I am here at the request of Dr. Gordon, who received the letter which you have in your packets regarding different types of licensure. The challenge is before this Commission, looking at some of these issues

of public safety, access, and also freedom of choice. We believe that you can use licensing as a mechanism to address some of these issues. So how you can maintain freedom of choice, access, with accountability?

So, professions that are trained to diagnose, to treat, and to prescribe, licensure really is the only answer, whereas, for herbalists or root doctors, maybe certification or registration might be more appropriate. Let's make these two distinctions, there is the title act and the practice act, both are licensing acts.

So, a title act sets up educational standards and defines the therapeutic modalities that a practitioner may use. For example, a naturopath would be an example, so there would be four-year degrees, licensure from accredited schools, and passing of a national exam.

Then the therapeutic modalities may be nutrition, herbs, homeopathy, hydrotherapy, but this title act does not restrict the practice of these modalities by anyone else, by a chiropractor, by herbalists, or by homeopaths. So the title act gets you to call yourself an ND, or naturopathic physician, but it

does not restrict these.

However, a practice act, like the Medical Practice Act or Chiropractic Practice Act, clearly does those same two things, yet it defines the scope of who can practice medicine or who can practice chiropractic.

Some of the disadvantages of that would be like the chiropractors in North Carolina don't get along so well with the physical therapists, so there are some turf battles and competition and fighting there, whereas, in North Carolina, the acupuncturists have a title act. So acupuncture is practiced by chiropractors; it is practiced by MDs, but you cannot call yourself an acupuncturist unless you have met these certain standards.

So, a title act would do five things, which you have listed there. It would support competency, set educational standards, and protect the public. This is important for public confidence, it really is. It would also provide access to CAM providers, like naturopaths. In Washington State, where there is a license, there are over 700 naturopaths.

In my state, where it is unlicensed, it is a

misdemeanor. We have a policy, don't ask, don't tell, and there are only 12 of us there. So, the access to naturopathic medical physicians is being restricted. It clarifies the expectation in the marketplace.

So, the state where the eight-year-old girl died at the hands of an unlicensed naturopath because he was advertising in the Yellow Pages as a doctor of naturopathy, the mother did not understand that he had a degree that was from a mail-order school.

DR. GORDON: Susan.

DR. DELANEY: Do I have to stop? Okay.

So, we are recommending licensing.

DR. GORDON: Do you want to conclude with a sentence or two?

DR. DELANEY: Well, we would like to recommend licensure for naturopathic physicians, using a title act or a practice act, but preferably the title act. It allows for more flexibility. Thank you.

DR. GORDON: Thank you. Thanks for coming back and talking with us again. At least up here, we don't have copies of your testimony.

DR. DELANEY: There was a letter that was sent

to you. It should be in your notebooks.

DR. GORDON: We don't have it.

DR. DELANEY: Okay.

DR. GORDON: So if you could send that again, we would appreciate it.

DR. DELANEY: Okay.

DR. GORDON: Questions from commissioners, questions or comments. Tom.

MR. CHAPPELL: Dr. Benor, thank you very much. I am just curious to know why you want to know how it works.

DR. BENOR: After spending 20 years researching this -- this book in front of you is a baby of 20 years gestation -- I have got a lot of curiosity because of the different ideas and theories behind what different practitioners say that they do.

I don't know that it is going to make a difference to the person receiving it, but sometimes it does make a difference in how it is delivered. For instance, people believe that prayer is different from mental intent. I don't know that we can ever prove it, but I think the investigation of this would bring us

closer to working together with people who know how to pray pretty well, pretty effectively.

And so, the process of exploring it, I think, would help to bridge some of the divides that our society has brought into being.

The average doctor feels that prayer is the province of the church, but I think it should be the province of every health care provider, to some degree, to whatever degree they are comfortable.

MR. CHAPPELL: Thank you, that does sort of provide motivation for me, as well. Have your studies included alcoholism?

DR. BENOR: There is one study by Scott Walker of alcoholism that was funded by the NIH. It showed that there was a greater percent of people persisting in treatment, although the effects of the treatment were no better with those who were prayed for by the people who were designated to pray.

DR. GORDON: Dan, you are referring to a study where people are being prayed for, not a study where they are praying?

DR. BENOR: That is correct, Jim.

DR. GORDON: So it is an intercessory prayer study?

DR. BENOR: Yes.

MR. CHAPPELL: I see. Thank you.

DR. GORDON: Joe.

DR. FINS: Dr. Benor, I just want to ask you, we have had a lot of discussion on methodology, and, how do you know if something actually works or not, and a paper that we briefly discussed yesterday was by Andrew Vickers' "Do Certain Countries Produce Only Positive Results: A Systematic Review of Controlled Studies."

In your own work, how have you addressed the biases or the accuracies of the studies that you cite? What are the criteria that you use for inclusion in your work?

DR. BENOR: I looked for randomized, double-blind, controlled studies, and in the book in front of you, I have ranked them according to whether they adhere to the minimum of scientific standard. The book you have is the first of two. The second will be a professional supplement, which includes many more details of the studies and the statistical data, for those who are

interested in those details.

Your question is a proper one. The book contains a little sheet there, listing the studies that are of high standard, and you can see that there are a good 30 studies there that I classify as of high standards, and they are not just in humans, they are in animals and plants, as well.

DR. FINS: Just a brief follow-up. Do you have any kind of concrete recommendation for the research infrastructure and how to bring increased methodologic rigor into NCCAM and training programs, any ideas along those lines that you could share with us?

DR. BENOR: I would strongly encourage people who are setting out on doing studies to seek expert consultation. I sometimes weep over the efforts that have been put out to do major studies where there are serious flaws that could have been avoided with proper consultation.

DR. GORDON: Charlotte.

SISTER KERR: You know that expression in the lay press when you want to read a book, about I can't until the end? So I want to ask you a question before I

read your book.

For example, I know you studied Olga Worrell and Meitk. I don't know if you looked at other conventional doctors or nurses who seem to have unusual results. Did you find that there were five major factors that facilitated this particular blessing on people?

DR. BENOR: I love your question, and every time I think I have the answer to it, someone comes along to show me that I am wrong. But on the average, compassion and love and caring, and a belief in something transcendent that can bring in a change that is beyond what we would expect within conventional medicine, can make it possible.

We don't have all the answers in conventional medicine, much as we would like to believe that we do. I have seen, myself, several healings that were medically impossible. I have heard of many others where people were transformed when there was no hope within conventional medicine. But something happened. We don't know how that happens yet.

That is part of my interest in further research. How can it be that someone with a cancer one

day can be without cancer in a few weeks or months, sometimes instantaneously? That begs us to do further research.

DR. GORDON: Excuse me. We only have five minutes. I wish we could go on longer, but the delayed David Molony has now arrived.

Welcome.

We want to hear his testimony. I don't know if there will be any time left to talk with Dan. So, I'm sorry to cut short the discussion.

David.

MR. MOLONY: Actually, my testimony is shorter than usual, too. So perhaps there will be time.

Thank you for allowing me to speak to the members here today. I am Dan Molony. I am a professional acupuncturist and executive director of the American Association of Oriental Medicine, founded in 1981, and the oldest and largest national organization of acupuncture and oriental medicine professionals.

We were instrumental in creating the National Certification and Accreditation Commissions for acupuncture and oriental medicine, and for passing

licensing statutes in many of the 40-plus states that are licensed.

Providers of primary care services include, in China, nearly three-quarters of a million doctors of conventional medicine, and over half a million doctors of traditional Chinese medicine. These two different systems of medicine coexist harmoniously because the Chinese citizens have equal access and a basic understanding of both systems.

Their conventional medical doctors were raised in a country familiar with its own tradition, while their doctors of traditional medicine have training that encompasses an evolving system of medicine that is rounded out with a year or more of conventional diagnostic and therapeutic principles and procedures.

Both professions are thus reasonably well prepared to help patients make informed decisions about their health care options. We support similar direct access to oriental medicine professionals in this country, who are well trained and licensed as primary health care practitioners providing independent services to a wide spectrum of patients.

We also support access to oriental body work therapists in their own right, and whose standards of practice leave little potential for confusion of their services as a substitute for comprehensive medical diagnosis and treatment.

The MM is working to bring professionals to the table to begin a dialogue to create a basic, entry-level training standard of oriental medicine modalities across the board within all fields of medicine in this country.

Nobody is sure how this will look when it is finished, but any neutral party can be sure that those with financial interests in training any particular group's practitioners should not be a participant in the discussion.

Discussion and development of these criteria must become disentangled from the politics of the educational processes of our disparate fields and evaluated by those with lengthy, clinical expertise from those fields, so as to provide input from the patient's perspective, since it is the patient who is at risk.

This sort of seed of change is something the that White House Commission has been commissioned to do

and will require a small but vigorous stimulus to germinate the beginning of a major change in the field of oriental medicine which might provide a template for further change within CAM with all its Shiva-style arms, many working against each other, to the patient's detriment.

The MM would be proud to work with the Commission to help in whatever way we can in order to enhance public safety and professional efficacy on the patient's behalf.

I would like to thank the Commission for your efforts to improve health care in America.

DR. GORDON: Thank you very much, David.

We probably have time for one more question for any of the three panelists. Does anyone have a question?

[No response.]

DR. GORDON: Okay. I want to thank you for returning and for speaking with us, and for making it here. We really have appreciated this input today, and your ongoing input to us.

Dan, I think if you have any specific suggestions -- I think this is what Joe was asking for in

terms of research methodology -- we would really appreciate it, around issues of spirituality and spiritual healing, because, and I don't know if you were here for that section today, we are really in the early stages of formulating our approach to it.

Even though we have thought about it a lot, we are still kind of coming together on it right now. So, any thoughts that you want to send us, if you want to send us criteria or any thoughts at all, based on your years of study, we would appreciate that.

Incidentally, I don't know, Susan Delaney, if you heard our discussions, we are grappling with licensure and have very much appreciated input about title licensure. It has been an important educational process for us.

We are going to adjourn now. Tomorrow, I want to remind everybody, we are meeting at the Bethesda Marriott Suites, 6711 Democracy Boulevard. There are maps at the desk. We are starting at 8:00 tomorrow. We will begin at 8:00. The first session will be on Coordinating and Centralizing Federal CAM with Don Warren, with Joe Kaczmarczyk, leading.

We will take a break, then we will spend some time talking about our responses to the events of September 11th. We will devote some time to new issues, talk about preparation of the Final Report, and we will adjourn by 12:30. Beth Clay will also be speaking with us early in the morning, right after the introduction.

So thank you all for this long and full day, and for all your attention and contributions. See you tomorrow morning.

[Applause.]

[Whereupon, at 4:53 p.m., the meeting was recessed to reconvene at 8:30 a.m., Saturday, October 5, 2001.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE THE: White House Commission on Complementary and Alternative Medicine

HELD: October 4-6, 2001

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

DEBORAH TALLMAN, Court Reporter