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WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

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Volume I

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Thursday, December 6, 2001

8:25 a.m.

Neuroscience Building
National Institutes of Health
Conference Rooms C & D
6001 Executive Boulevard
Bethesda, Maryland

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C O N T E N T S

P R O C E E D I N G S

[8:25 a.m.]

DR. GORDON: Good morning, everybody.

So now that we are here, it's time for us to begin. So let's just sit for a moment, collect ourselves, and be present for this work we have coming up.

[Moment of silence observed.]

Welcome/Opening Remarks

DR. GORDON: Once again, welcome, Commissioners, our staff, and our guests. Bill Fair and Dean should be along very soon, I believe. David Bresler won't be here, George DeVries won't, and Buford Rolin won't. Either illness or emergency has called them away, kept them from coming. Either their co-facilitators or staff will be filling in, as appropriate, for them as time goes on.

This is obviously a very important and, in fact, crucial meeting for us. Since the October meeting, the workgroups have done a great deal of work and have produced a number of recommendations, and the task for this meeting is to come to consensus about as many of

those recommendations as we possibly can.

Since there are 87 recommendations, it is a significant task. So we are all going to have to work at this together.

The structure of the meeting is going to be that the facilitator or facilitators of the workgroups, with the help of the staff, will be leading the majority of the segment on each of the topics that we are covering. In the last 15 minutes, I will be summarizing where we are as far as consensus goes.

The first part will be for a very brief presentation of the progress of the workgroup, and then we are going to move through the recommendations one by one, look at them, and the assumption will be that all of us have read the recommendations carefully, and the issue will be discussion about the recommendation and discussion about the issues that the recommendations grow out of.

What we would like is a consensus, either the recommendation is accepted as it is presented, that specific changes in language are approved, or the recommendation is deleted, or in very, very, very rare

instances, that the recommendation goes back to the workgroup for further discussion, in which case the workgroup will be working with whoever is prompting the further discussion, whoever has got the major issues, major concerns about the recommendations, and we are asking all those workgroups and all those others who will join the workgroup to turn around that recommendation in 10 days.

Again, the emphasis is on coming to consensus here and now. The way it will work is the facilitators will be in charge of the discussion. If Steve and I, in our wisdom, feel the discussion is bogging down, we are going to sort of move in and say the discussion is bogging down, we have got to come to a very rapid conclusion, because each of the sections has a number of recommendations.

There will be plenty of time, and we expect everybody to put on the table what their concerns are about the recommendations. If there is something that is troubling, please say so, this is the time to do it. If there are real concerns, voice them now.

At the same time, this is also the time to put

aside parochial concerns in the interest of producing a document which represents us and especially represents the principles that we have enunciated for who we are and what we are about as representatives of the American people and of this movement.

I am going to be, and perhaps others will, as well, calling us back to our principles, to our basic principles as we move ahead in the discussion.

Another issue is that at the beginning of the discussion, when each facilitator asks whether or not there are gaps for which recommendations need to be presented, everybody will have an opportunity to raise your hand, and then toward the end of the discussion, there will be an opportunity to present those so-called gap recommendations.

That is, if something has been left out, particularly something that has been left out that reflects the principles and has been enunciated before by the Commission, say, in the October meetings, or something else that seems particularly essential, there will be time, and we are asking the facilitators to leave time at the end of their discussion for those gap

recommendations.

Again, this is really our last major opportunity to pull together, to come to consensus about these recommendations. We will be having another meeting in February. We hope that most of that meeting will be devoted to discussing the wording of the final report.

We want, and fully expect, that all recommendations will be made in this meeting or resolved by the workgroup and the additional members of the workgroup in the 10 days or so following this meeting, so that the February meeting will be just for cleaning up a little bit of what is left and for focusing on the text of the final report.

We will be having lunch together today and tomorrow, and we will sort of have an opportunity just for informal exchanges at that time.

Steve.

Charge for the Day

DR. GROFT: Thank you, Jim.

My welcome also, it is good to see you. A lot has gone on since our last meeting, and I don't want to take too much time going over those things. We will talk

about several things at the lunch breaks and as we go on into the meeting as far as the format for the report and the process later on.

I just wanted to ask if any of you received this yellow folder from Mandy Stoneberger, if you could please fill it out and return it either to me or Mandy, if she is still here this morning. Mandy is over here on the side, she dropped several of them off. Please, we need this to express any outside activities that you are involved with.

We occasionally get requests for conflict of interest status of the Commission members, and if there is anyone paying any attention, and this is one way for us and the government to say, yes, we are aware of what you are doing on the outside, and there is no real problem with us being aware, it is okay for you to continue to do those things.

Were you able to download the various attachments that I sent on Tuesday morning, Tuesday afternoon? It would have been one on the potential responsibilities and activities of the proposed federal CAM Coordinating Office.

[Show of hands.]

DR. GROFT: If you did not get those, I will pass them around. I will pass these around. Another one was the revised outline for the report, if you didn't download the first one, you didn't download the second one, I am sure. My apologies. We are working on these things, trying to get the things put together.

I have one more thing to talk about. I will save that probably until tomorrow afternoon when we will talk about the format for the various issues that will be expressed in the final report.

As Jim mentioned, the goal of this meeting and the charge to come to some conclusion on the recommendations. We need this closure to enable us to write the report.

Now, we did expand the text from the last meeting. I don't know if we will have enough time to go over the text, but if you have problems with what was written or how it was written, whether it's content or tone, we would like to hear that.

If we don't have time to talk about it here or to mention it briefly, we really would appreciate it if

you could send your comments to us. If you like, I think we need to develop a system that you can share your comments with everyone.

Does this sound like something that you would like to do? If we can do it electronically, we will just have the Reply to All button, and then everyone will get a chance to see what your concerns are. I will ask you to do that.

In fact, I will follow up this meeting with a note to you, and then that become your key to send out to everyone else, and we will make sure that Veronica gets a hardcopy -- I mean, not Veronica -- Charlotte gets a hardcopy via the fax, since she is not using the computer. So, please, if you could follow up on that, that would be good.

We have got several thoughts about the format for the report that we will be talking about again, maybe at lunch today. I will just ask you, to reiterate what Jim said, we need to get a consensus and agreement. It may not be what we like, it may not be the ideal situation, but I think the situation, if you can live with it, think along those lines. If you can't live with

it, then, we have to change it.

Any questions at all?

[No response.]

DR. GROFT: I guess I will just call the first group up, Jim Swyers and Tom Chappell and Wayne Jonas.

Discussion Session I: Definitions and Guiding Principles of CAM

DR. JONAS: Excuse me, a question. The guiding principles that are in here, and I don't see the version that we wanted to discuss.

MS. CHANG: He is making them now.

DR. JONAS: He is making them? Okay. While he is handing out those, if you would replace the version that he is hand out with the guiding principles, let me just kind of summarize what we did since the last meeting related to the Definitions and Guiding Principles section.

Based on the comments of the Commission at the last section, we did a number of items including move the principles to the Introduction. Before, it was not in the Introduction, and now it is in there towards the back part, after kind of the historical and the description of

the area.

We reshaped and reordered them, and you will see in the version that he is handing out what their current form is. There was more emphasis overall in partnership and relationship among all parties in the healing process, which was something that was emphasized last time.

We added statements throughout about the inclusion of mind-body and spirit to present kind of the holistic perspective all the way through, and environmentals, I don't know if environment got in there on a regular basis, but that was one of the items that was mentioned.

Emphasized the principles of safety a little bit more than they were in the last time, as well as efficacy, so safety and efficacy, so linking those together.

We related these principles to others that we liked in some other reports, specifically the IOM report on continual improvement of health care that has recently come out and which some of the principles paralleled a number of ours, such as healing, you know, the fostering

of healing relationships, for example.

There is a whole history section, which now has been expanded and that has gone into primarily the demographics around CAM use in a variety of subpopulations beside the American public as a whole, including some selected prominent conditions, populations with certain conditions, as well as various ethnic groups and their use of complementary and alternative medicine.

There is a diagram developed illustrating the relationship between health promotion, wellness, illness, and its treatment, which is going to be handed out also.

In terms of the introduction to the report, the current version that you see, which is actually in the back of the book, is a version that our working group has not actually reviewed yet, so if everyone could look at that.

The history part of it, which is an expanded version, is fairly new, so if we could look at that. If there are any other issues, for example, if there is recommendations from groups like the Pew Charitable Trust, for example, or other recommendations that you think we should link things to besides the Institute of

Medicine report, which is the primary one that we have highlighted, then, that would be something that we would like to know, and then there is a variety of minor edits and things that we can go through.

I think what I would like to do is first get a sense of the overall organization of the document, understanding that the Guiding Principle section that was just handed out, should be substituted for the Guiding Principle section that is in your book.

Right now the idea is that this would go, starting on page 12, this is the back of the book. It is under Tab 12, General Information, CAM Background Information, even though we are dealing with it first.

Has everyone located that?

MR. CHAPPELL: Would you repeat that again?

DR. JONAS: In Tab 12, Background Information in the back. It is called General Information. The tab is called General Information, and then the cover sheet is called CAM Background Information.

It starts with page 1, the first section through page 12, actually is basically the historical descriptions, it is the preamble, if you will, gives the

background that illustrates primarily the demographic issues and historical issues, but in a much more expanded form than we have seen in the past.

It also outlines, on page 11, what the current charge is for the White House Policy, and then on page 12 are the guiding principles of the Commission. For that, you should substitute what Jim just handed out instead of what is in there, which is a revised version of the principles.

Starting on page 12 is where we link it to the IOM Report on Quality Chasm.

I think what we need to do is, first of all, the overall organization of this section. It is my understanding that this is going to be at the beginning of the book, so starting with the Historical section, the outlines of the principles and then the definitions.

Tom is going to talk about the definitions after we finish this section.

Yes?

DR. FINS: Just a quick question. What is the relation of this tab to Tab 6?

DR. JONAS: None.

MS. CHANG: I don't know that the distinction is meaningful. It is just that we are going to be discussing all the pieces of that section, so introduction, definition, and principles are kind of in that section.

DR. JONAS: My understanding is that -- again, I haven't verified this with the current order of the report -- but my understanding, and correct me if I am wrong, Jim, that what is in Tab 12 is going to be the first part.

MR. SWYERS: Yes, that will be Part 1, the Introduction.

DR. JONAS: It will be followed by what is in Tab 6, is that right?

MR. SWYERS: Yes. Tab 6 will be Part 2.

DR. JONAS: Whether these should be one or two parts, I don't know, but they are currently laid out as two different sections. I see them as very linked. I mean, they are the general history, description, definitions, guiding principles, kind of the background information, and the orientation that the Commission is operating out of.

DR. FINS: Do you want us to discuss the thing as a single unit?

DR. JONAS: What we are going to do is we are discussing the ones I just described now, in Tab 12, and then we are going to go directly to the definitions. So, yes, I see these really as a single section even though they are divided as Section 1 and 2. I see these as kind of conceptually a single section. They are the background and orientation to the report itself.

MR. SWYERS: I mean, the way I have envisioned it is that the first part will set up the second part, and the second part will set up the rest of the report.

DR. JONAS: So, right now we are focused on Section 12 as I have just described it, and Charlotte has made a comment. Charlotte, do you want to make it, about the guiding principles seeming a little bit -- or I think in the order of the Guiding Principles behind the Background?

Are there any comments on the overall organization of this? Do you like starting with the demographics and having that filled out first, and then going into the guiding principles or vice versa?

SISTER KERR: My only comment at the moment is I am not sure, and so now it's okay because I know Jim has taken me through different stages of how you write and all, but I guess I am trying to think of what is not only informational, but effective and beginning to read the report, and I am not so sure the demographics might be the first place. It might be the history.

I am just kind of taking that in at the moment.

DR. JONAS: Do you have a comment? Yes, Joe.

DR. FINS: I think the demographics is a good place to start. I think it is neutral, it makes the claim, and I just would add, just tweak it a little bit by saying this really remains a public health issue based on utilization, based on interactions.

You talk about some of the drug interactions, but I think it validates it for the non-CAM reader about why we are doing this and why it's important. I think you make a convincing argument for that, and I think the demographics is a neutral place to start. I will have other comments about the History section later.

DR. JONAS: This is the more traditional way CAM is introduced in almost all places, is they start

with, guess what, the public is using it, these are the issues that that brings up.

DR. GORDON: I think it is also important to give some sense of history, not the entire history of alternative medicine, but the recent history of the growth of CAM. It kind of spring, the demographics spring a little too naked out front, so it needs that sense of where this is coming from, what has been happening in recent years, and why, a little bit about why there is so much.

MR. SWYERS: Jim, how far back would you go with the demographics?

DR. GORDON: Really, the last 30 years. That is the period in which this modern CAM movement has really taken shape and taken form. I think that people need to be oriented a little bit here as opposed to waiting until later on.

DR. JONAS: Right. So, in other words, something about the trends.

DR. GORDON: Yes, trends and some sense of why, as well, why is this happening, because again, for the non-CAM reader, it is embedded some in the demographics,

but I think there needs to be some sense upfront of why this is going on now, what this represents.

DR. JONAS: Right, I agree. I think what has been startling is how widespread the use of these practices are, and that is kind of what this is saying, but even more startling is the growth.

I mean, if you look, just Eisenberg's two identical surveys, that was even more startling I think to most people.

DR. GORDON: Excuse me. Joe just asked if the facilitators could sit at the table there with Jim Swyers, so everyone can see. I think it is a good idea. Tom, if you want to sit up there, too, with Wayne. Thanks, Joe.

Incidentally, I am not saying that it absolutely has to be led with that context, but it has to be woven into the demographics somehow, so that we orient people.

DR. JONAS: Right. So, something about the trends, so a little bit more of the history and also something about the reasons for CAM use and why they have become kind of more in the public eye now and why there

is an interest in them. I agree.

My feeling is that part of the trends are not simply the fact that the public has an interest in them, but there are some compelling public policy issues, such as the escalating costs and the concern over adverse effects, for example, in conventional medicine, that has resulted in increased interest, not just among the public, but among those who manage health care policy also, and there should probably be something about that in here also, right upfront, to show there are many compelling reasons simply besides popularity that make these important areas to address.

DR. LOW DOG: Just I think if we are going to do that, you need to also balance that with the marketing influence. I think you need to balance that with in vulnerable populations, sometimes the treatments seem absolutely brutal and horrid, so if you believe that you could take a tincture of herbs that will make everything disappear and get better, then, you may be more willing to do that.

I think that there needs to be a balance of why. I don't think we completely understand all the

reasons of the phenomena of CAM, and I think we need to be upfront about that, and that there is probably a lot of different things mobilizing it.

DR. JONAS: Okay, yes. There is a section on safety in here as being one of the main concerns, and I see that also as a policy -- I mean, it is obviously important for individuals, it is also an important public health and a policy issue reason for addressing these.

Any other comments?

DR. FINS: I think we also have to have a comment on the psychological motivations of many people, and the people who are desperately ill are looking for the less burdensome intervention even if it may not be as efficacious.

I don't know if this is the time to bring it up, but I found in the History section, since we are talking about the relationship of history to this, and looking for causal explanations for the rise of CAM, you know, this looks like oh, my God, the Flexner Report came forward -- by the way, Flexner is not "or," it's "er" -- and there was a rise of medicine, and horrible things like sulfa drugs and penicillin, and that led to the

decline of CAM.

DR. JONAS: Are you looking in Section 6?

DR. FINS: Six.

DR. JONAS: We are focused right now on Section 12.

DR. FINS: I appreciate that, but Jim brought up the issue of motivations and why CAM has had this ascendancy, and I don't think we want to go back to the pre-antibiotic era. It reads like a Luddite kind of view, it's anti-intellectual, it's anti-science, and it's anti-medicine, and half the people in this room would have died of childhood infections if they hadn't had antibiotics.

So, I really think when we look at causal -- maybe that's an overstatement -- but the point is that many of us in this room -- you know which half --

[Laughter.]

DR. FINS: So, I think it is important to be very careful in invoking causality, because the social science is not there, and then it begins to look like an advocacy piece.

MR. SWYERS: Joe, to respond to that, we have

identified that as a problem with that section, because I was given a limited set of references to work from, but I have gone back now and looked at some of the broader literature.

DR. GORDON: I would agree. I think it needs to be a very balanced section, that we have to present the strengths of the Western system of medicine, as well as some of the reasons why CAM may have emerged, and Tieraona was referring to some of those, as well.

So, I think we can do it in a very balanced way, and I would agree.

DR. JONAS: So, information about the advertising, information about the psychological motivations that may be driving individuals, as well as perhaps the links with some of the historical things that have been traditionally motivators in these areas, such as, you know, all the weight loss types of trends and kind of the fitness trends, and that type of thing.

DR. PIZZORNO: Two things. First, Joe, I would not want to go back to the pre-fungal/antibiotic age either. There is a couple language things I would like to request here.

One in particular is the use of the term "physicians" to be synonymous with "medical doctors." So, for example, I was looking on page 4, where it says, "patients suffering from chronic back pain choose chiropractors or physicians to treat them," you know, many chiropractors are designated as physicians in their states, as are naturopathic doctors designated as physicians, so I think we have to clarify that.

MR. SWYERS: I think that is something we can deal with as we get further on in the report. What I have developed is a style sheet for the final report, so I think we can deal with all those sorts of issues to be sure that we are using the correct language.

DR. JONAS: Joe.

DR. FINS: Again, since this is the only time we have allocated to discuss this, and depositions and history are intertwined, and I think the latter section is less contentious than the Section 6.

I just worry about this CAM creep phenomenon in the sense that we are saying that CAM has done something that other disciplines have not done, so you talk about psychosomatic medicine, which was a beginning, but now

CAM is really into the mind-body thing.

I am reminded that there was psychiatry --

MR. CHAPPELL: Joe, we are coming to that section, if you could reserve those comments to that section, then, I think they will fit in very well.

DR. FINS: Okay.

DR. GORDON: Just a brief comment on the studies. I think there needs to be just another look at the examples that are chosen. For example, there is one that just puzzles me, about the cancer patients, that the use of the modalities was highest before surgery and tapered off.

This is a general comment. I think that when we select examples, the examples have to advance the points we are trying to make. This one just kind of befuddles me a bit as to why it is in there, because there are so many examples.

MR. SWYERS: I agree. Right now this is kind of a kitchen sink section. We are just kind of throwing everything in there. We need to weed some of it out and substitute. Your point is well taken.

DR. JONAS: Along those lines, are the

examples, the general examples about efficacy and safety, are those good ones for folks?

DR. GORDON: General examples, Wayne?

DR. JONAS: Yes.

DR. GORDON: Yes, I think in general, that they are, that you are addressing some of the major reasons why CAM is being used. I mean, the examples about use in pain or use in cancer --

DR. JONAS: Page 7 and 8 deals with the evidence base, looking primarily at efficacy, and then page 9 and 10 deals with safety.

DR. GORDON: Page 8 begins with the acupuncture discussion.

DR. JONAS: Well, actually, starting on page 7, there is a discussion of basically, here is evidence for certain selected areas, and these are selected.

DR. GORDON: Yes. I think generally, the examples are good.

DR. JONAS: If there are particular ones that people think are pertinent, especially pertinent to here, if you would let Jim and us know, then, in terms of the examples throughout that, and your example of the example

of cancer is an excellent one, but also on the general safety issues, as well as the efficacy issues.

DR. FINS: On page 7, we talk about the pain issues, I would say a couple of things. One is that this is all against a backdrop of the undertreatment of pain and the inadequate training of allopathic doctors in pain management, but I would also caution you there, I think was the Motrin study talked about attitudes of consumers in using non-steroidals or non-prescription medications.

Many of the same arguments could be made, and it was basically they wanted to maintain control over their own situation, and they didn't want to cede any kind of control to physicians or to more powerful medications, and there was a denial phenomenon.

So, some of the arguments that are being made for the use of CAM modalities could also be made for over-the-counter medications, and I think we should probably also cite, since we don't know the causality, we would be very careful, but some of the same sociologic factors lead people to use over-the-counter meds, not seek a medical physician's input, that might also lead to their seeking out an acupuncturist or a massage

therapist.

DR. LOW DOG: I would have liked to have seen, when you were talking about, you know, like depression, the CAM approaches, I would have actually been specific what it was about, was it St. John's wort for the treatment of depression, was it Fever Few for the treatment of headache, and also that reference isn't in there, Jim, so you know, those of us who were trying to find some of these references, you don't actually have them.

But what actually did we find, and was it glucosamine for arthritis. I think it is important to know which of these we are talking about when you are there, because a number of these are actually product, and not service.

I think that when you are reading it, it is important to see while we are sifting through, what have there been systematic reviews for, and what actually showed them to be effective in there, and just double-check your references, make sure they are in there.

DR. GORDON: I think that is a good idea. I think, too, that where there are examples that are

illustrative, you don't have to give an example for every one. That will help grab the reader and give the reader a sense of what we are talking about.

The other thing, I think a point that should be made is that research has usually followed popular use, and I think there needs to be a sense of how this has all developed. That is a one-sentence kind of thing.

I just think that again, a little bit of history, that first there was the use, and then there was research, often, in the case of herbals, research was overseas, and then it came here and we began to look at it here, that kind of perspective can be helpful.

DR. JONAS: Right. So how the use then led to research. We already in some specific discussions, which is fine.

DR. WARREN: It was the marketplace that eventually drove the research. It was capitalism that basically drove the research.

MR. SWYERS: We do make that point a little bit. We say that surveys documented the rise of interest in use is what led to efforts to investigate these.

DR. JONAS: Any other comments? We are already

into the specific areas, and that is fine. I am going to let the group go in instead of go through one by one.

DR. ORNISH: Well, just as a matter of process, I wasn't quite clear. Are we talking about Section 6 here, the Definition section?

DR. JONAS: No.

DR. ORNISH: Then, when will we be talking about it?

DR. JONAS: Right after this.

DR. ORNISH: But in your session, though?

DR. JONAS: Yes, in about five minutes, yes.

Any other general comments on this introductory section or specific comments as you look through it? We can go through it one at a time if you want. We have already gone into the Efficacy, Safety, and the Reasons section.

DR. PIZZORNO: Just a simple wording question. On the very first page, it says, "Who uses CAM, for what and why," and then it says, "The demographics of CAM." Shouldn't that be, "The demographics of CAM users," is what is actually being described there?

DR. JONAS: Yes.

DR. ORNISH: I was going to say you might want to talk about CAM and heart disease, you know, the kind of work that we have been doing, because it has probably got more scientific documentation than anything, certainly compared to these things. It might be a nice way to kind of give some credibility in an introductory section.

DR. JONAS: I agree. I think that would be excellent, even maybe a couple-sentence description of that rather than just a listing of it.

MR. SWYERS: Basically, this is just showing where there have been systematic reviews of the areas and that we do have that as one of our bullets, heart disease as one of our bullets, but I don't go into the individual studies at this point.

DR. JONAS: But some more specifics in terms of what modalities and also what systems or practices especially where there is good evidence.

DR. ORNISH: But, for example, on page 8, you have got heart disease as kind of the last thing, but, you know, we have got such good data, not only medical effectiveness, but cost effectiveness data, probably more

than anything else in CAM right now, it might be worth mentioning or highlighting that just to show that there is a scientific basis for some of this anyway.

DR. JONAS: Right. I think that is a good idea.

DR. GORDON: Wayne, I am going to suggest that pretty soon we move on to the Principles, because we have Principles and Definitions to do.

DR. JONAS: Let me know when our time is up for this, because I am not going to go through this thing section by section, we are doing this right now, so if you have anything to say about this particular section in terms of details, let me know.

DR. FINS: I don't know if this was an error of omission or commission, but remember we talked about the Ven diagram, and we talked about the various spheres and the overlap and the integrated? Whatever happened to that, it is there.

MR. SWYERS: It is hot off the press. I will pass it around. People haven't really had a chance to look at it yet, so I think discussing it today is going to be difficult.

DR. FINS: Is it going to be in this general part of the thing?

MR. SWYERS: Yes. I think if you give us comments back on this, I will pass it around.

DR. FINS: I just want to make a point just to sort of maybe telegraph that a little bit. Nowhere do we really mention -- we talk a lot about partnership, which I think is great, but I think, you know, words like "integrative" should be in here somewhere.

It looks very dichotomous, like you are either/or, and a phrase that I would like inserted is that even though there may be two parallel systems of care, our patients move freely between them, and therefore, it is a public health mandate for us to have a patient-centered focus versus a system-centered focus, just something along those lines, Jim, if you could drop that in.

MR. SWYERS: Very good point.

DR. JONAS: Let me just make one mention about the Ven diagram. What is going to be passed around is not the Ven diagram for this, at least as I envisioned it. We had talked about it before, and it is not in

here, and as far as I know, it is not in development, but I think we should do this, and that is, an actual Ven diagram where you can show overlaps of various types of modalities, so that people can see that these are not exclusive domains.

We will work on that. I think that is an excellent idea. There was an article in JAMA about six months ago which talked about kind of how people use health care, and it expanded on this traditional most people who develop symptoms don't go to see anybody about it, they self-manage.

Then, the next layer, they go to family and friends, then, they go to over-the-counter, then, they go to primary care, et cetera, et cetera. It was a very nice database, a description of that, and it included complementary medicine use in it for the first time, and it kind of showed this fluidity in terms of how people actually make health care, and that I think might even be a very useful thing in itself, and it is in the medical literature and well referenced, and it shows how things relate to a variety of other kinds of health care practices also.

DR. PIZZORNO: Could you give a reference? I would like to take a look at that.

DR. JONAS: Yes, I will have to pull it up for you, I forget the exact reference. It was about six months ago.

MR. SWYERS: I would like to say by the time you see the next draft of this, we should have that ready, so by the time we meet again in February, we will have a chance to look at it, and we will get feedback from everyone.

DR. JONAS: But I like that, I like that idea of putting that in as a visual to show the overlap and kind of the use in terms of the context of what people actually do.

Any other particular comments about this section before we go to the Principles?

DR. FAIR: I just had a comment. I realize it's a demographic description here, but, for instance, CAM and cancer, every time I hear Michael Lerner talk, and, Jim, at your meeting he did, he starts off by saying he knows of no complementary and alternative medicine that will cure cancer, and the implication here is the

fact that 40 percent of people are using CAM means that there is some -- maybe I read into it too much -- but that means it's effective.

I would like a sentence in there just to more or less clarify that the fact that people are using it does not necessarily mean that it's effective, and most of the CAM effectiveness are for less serious conditions, and when you get cancer, there is not a lot we can do for it.

DR. JONAS: Although one wouldn't necessarily make the same statement for heart disease, is that right?

DR. FAIR: That is exactly right.

DR. ORNISH: Which is why you might want to highlight heart disease in there as an example of something that really CAM does have scientific data for.

DR. JONAS: Maybe that would be a good way of highlighting this, it is used for a variety of these things. In some cases, there is good evidence where it actually is useful as a treatment, and in other cases, it is not, and it is more adjunctive.

DR. ORNISH: But I also think it's important to clarify that it is not that it has been proven that CAM

modalities don't help cancer. I mean, we just looked at our data from a prostate cancer study we are doing, and we are finding -- with Bill actually -- and we are finding that it does seem to have an effect on PSA, but it is too early to know whether it has an effect on survival or metastasis.

So, I think it is important to distinguish between the fact that there may not be evidence yet versus that there is evidence that it is not effective, and I think we need to clarify that.

DR. FAIR: And the truth, it may have some effect in cancer. The problem is that with heart disease, hypertension, we may have a 15- to 20-year lead time, and with cancer, we have the same lead time, we know that, from the time the first cell becomes malignant until we can detect cancer, but we just don't have the way of detecting it right now.

DR. JONAS: Right, exactly. I think that is a good point.

MS. CHANG: Just a time check, Wayne. You have got about 28 minutes for the rest of your section.

DR. JONAS: Let's go to the Principles, the new

ones, not the ones that are in the original book, but the ones that have been just handed out, Guiding Principles of the Commission.

As you can see, what we have done in this section is that we have taken and put them, first of all, in the order of priority as they came out from our last rating, that the group as a whole came up with, and these were actually fairly strong.

I mean, the ones that are up at the front were really up at the front, and the others were kind of spread throughout, so these are not in any kind of fixed order other than the ones in the front just as a general comment.

Also, last time we spoke about the phraseology, to make it a little bit more clear in terms of not just single words, but a phrase that would capture the essence of what the principle is about, as well as another description. I will leave it at that.

I am going to open this for discussion.

DR. GORDON: I have one major and a couple of smaller points. The major one is you suggested deleting self-healing, which is No. 9. If because it is redundant

with which one?

DR. JONAS: Three.

DR. GORDON: With 3, okay, that's fine. What I would say, though, for No. 8, is there are two distinct ideas, at least in my reading of it, that are present there.

The first has to do with education, and the second has to do with providing information, so I would make the part of it that reads, "quality health care" as a ninth point, because that seems to me different from education.

"Quality health care can be enhanced by promoting efforts to thoroughly and thoughtfully examine the current evidence base for CAM systems and practices, and make this evidence base widely and easily available in a timely fashion." I would just add "to all Americans," and strike the last sentence.

DR. ORNISH: You just want to have a Top 10 list, admit it.

DR. GORDON: What, Dean?

DR. ORNISH: You just want there to be 10, so you can have a Top 10 list.

DR. GORDON: Yes, exactly.

MR. SWYERS: Actually, Jim, the reason it looks like it was two separate principles, because one of them had dropped off the list. I took the text out of that and just slapped it under there, so I will just take it, and we can just move that back out. I think that was the education one.

DR. GORDON: I saw the last sentence. It is just a repeat of what we said up under -- I wouldn't repeat it, because we said "evidence of safety and efficacy" right up under No. 2. That is the main -- and then I can wait on the others, so people can respond to that.

DR. JONAS: In other words, you would like another one, No. 9, if you will, that has to do with --

DR. GORDON: Providing information.

DR. JONAS: Right, providing widely available public information.

DR. GORDON: Yes, which I think obviously it is one of the basic principles that we have been very concerned about.

DR. JONAS: I believe that is also one of the

ones in the IOM report, too, I think. Let me look at that. Yes, No. 4 in the IOM report, "Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information" -- now, this is focusing I think primarily on records and this type of thing -- "but they should communicate effectively and share information, clinician, and patient."

So, again, the information one is No. 4 on their list.

DR. FINS: It is sort of in No. 2, but it is not explicitly stated, and I think it is something we had agreed on, was the phrase about protecting the public safety, the public health.

DR. JONAS: You mean protecting the public health?

DR. FINS: The public health or public safety. It is kind of buried in No. 2, and I think it was one of our top couple of issues, and it seems to have been morphed into something which is a little less fervent.

DR. ORNISH: What would you like it to say?

DR. FINS: Maybe if we just amended No. 2,

"Enhance the development and delivery of these services and products, and protect the public health," on No. 2, just add on "and protect the public health."

DR. GORDON: Say that again, Joe, please.

DR. FINS: On No. 2, say blah, blah, blah, "and generating the evidence that will enhance the development and delivery of these services and products to protect the public health."

Then, one other just point, on No. 4 --

DR. JONAS: "To protect and promote," how about that?

DR. FINS: "Protect and promote the public health," that's fine.

Then, on No. 4, the notion here of customized health care, I think we want to be responsive, but you can't always accommodate an individual preference with available science, so if a patient says they want an antibiotic for a viral infection, you know, am I supposed to customize their care and give them the antibiotic, you know what I am saying?

I think it sounds a little too consumer driven versus --

DR. JONAS: Yes, you do with education.

DR. GORDON: How about "appropriate to that uniqueness, Joe?

DR. JONAS: "Appropriately customized."

DR. FINS: But customized implies -- I mean, one day we will have designed chemotherapy and designer genomics, and everything, but that is based on a scientific basis. This seems too preference driven.

DR. JONAS: This is preference driven, and intentionally so. It parallels exactly the number two principle in the IOM report.

DR. FINS: I am in favor of patients having their preferences respected, but you can't always deliver on the preference without violating the corpus of the science or one's professional responsibilities.

DR. FAIR: Joe, I think you are talking about a different level of care. Let me put on my patient hat for a minute. I think preference is totally important. Science may dictate that you keep someone alive with an autologous bone marrow or try to, an autologous bone marrow transplant or something like that, because that is

the "state of the art," but it is still that patient's preference to say I don't want to go through that nonsense, I want to live for as long as I can live in dignity and a quality of care, and I think when the final analysis comes down, it's the patient's choice, and many people will choose not to go ahead with painful treatment and just live out their life as comfortably as possible.

So, it is different than giving an antibiotic to somebody. I think in the final analysis, it is the patient who makes the decision.

DR. LOW DOG: I understand what this is designed to say. I think all of us agree about wanting to respect patient preferences. I actually had never thought about sort of giving antibiotics for viral infections, but when I actually look and think about it in my own practice, what sometimes patients request, I am having a hard time sleeping, can you give me a bottle or two of Halcion, I mean, sometimes the requests are really not appropriate, and actually they violate good medical practice.

I think that you could fit examples in here that are not what we are trying to say, but I think it's

important because if you can't put examples in here that are inappropriate, then, maybe we need to relook at the wording here.

I do think we want to respect patient choices and that patients ultimately have the control over what they choose, but I had just never looked at it that way until you said it that way, and actually, there is room then for some real misinterpretation.

DR. GORDON: If that is not working, can we have a word?

DR. FINS: Instead of saying health care that is responsive to the uniqueness, you know, their preferences --

DR. JONAS: Why don't we just put appropriate?

DR. FINS: Responsive is always appropriate, but customize is not always appropriate, so "responsive," I could live with as a single standing --

Joe.

DR. PIZZORNO: First, I agree with your concept, you don't want to give an antibiotic or other drug to a patient when it is not appropriate, but "customized" does not mean just simply what the patient

asks of you. It means being aware of the patient's need, and providing what is most appropriate to them, and understand, hearing their preferences, but that doesn't mean you have to give them what they are asking for, but you have to treat them uniquely.

DR. GORDON: We need to move ahead, so what we need to get is a word, the way I see it.

Wayne.

DR. JONAS: I was going to suggest we put "appropriately" in front of "customized," "appropriately customized," because that is what we are talking about.

DR. ORNISH: I tend to agree with what Joe Pizzorno just said, that the fact that you customize something doesn't mean that you do whatever the patient tells you, but "appropriately customized" or "individualized," I mean, Joe, can you live with that?

DR. FINS: I know what you all mean, and I am sympathetic, but I am just trying to avoid the Dean Ornish land mine metaphor.

DR. ORNISH: Do you think that that would address the issue, if it either says, "appropriately customized" or "individualized"?

DR. FINS: I think "appropriately individualized" is something I could live with, but "customized," think is just --

DR. JONAS: You would prefer "individualized"?

DR. FINS: I think "customized" has a -- you know, we don't need to --

DR. ORNISH: Let's just say "appropriately individualized," and maybe we can all live with that.

I have a question about No. 10, though.

DR. GORDON: Do we have a consensus, that as the criterion goes, that we can live with here? Wayne, what do you have at this point?

DR. JONAS: Right now it is on the table as whether you want to use "individualized" or "customized," and I think everybody agrees "appropriately" should be in there, and, if not, please let me know.

Would people prefer "individualized" or what was the other word you used, Joe, "appropriately responsive" to individual or to the uniqueness?

DR. GORDON: It could be "appropriately responsive to that uniqueness." Is that something that we can live with?

DR. FAIR: Jim, I think we need to have in there that the patient can refuse treatment.

DR. GORDON: That's under a different one, that's under No. 5. That is more under No. 5. I think the point here, as we have enunciated, is really that there need to be unique treatments, and that is going to be different for each person, and people have a right to participate in all decisions in creating that unique treatment.

DR. JONAS: We will try "appropriately responsive" in there and then see how it feels. We will have another chance to final modification of it.

DR. ORNISH: I just wanted to mainly focus on No. 10 for a second, because there was something added here that wasn't in the earlier version of the binder, that I do see as a potential land mine, which is that when we talk about advocating advocates in an early document -- first of all, I think these guiding principles are really great, so this is a minor point to try to make it even greater -- but I really think that if we start looking like we are taking an advocacy position by advocating advocates, it might set a tone that we are

not really intending to do.

DR. JONAS: What would you call public representatives who participate in these various groups?

DR. ORNISH: I live the way it was originally, where it was just the first sentence. The second sentence is the one I have a problem with.

DR. JONAS: I understand. So, you don't like the word "advocates" in that particular thing, is that correct?

DR. ORNISH: No, because it is basically saying that we are so in favor of CAM, we want to have advocates everywhere advocating that CAM is good.

DR. JONAS: No, what this is saying is that we are so in favor of public involvement, that we think that public representatives, who are advocating for public input on these things, should be part of it.

DR. ORNISH: But they are advocating for CAM. I mean, isn't that the implication here? That is how I read it.

DR. GORDON: I don't read it that way. I mean, I can see how you might read it that way, I don't read it that way, I just read it as people who are advocating for

the public's concerns, whatever they may be. It may be for regulation for CAM, they may be for promotion of CAM, they may be for any number of things.

DR. ORNISH: Okay. I am glad to hear you say that was the intention because that doesn't come through for me.

MR. SWYERS: What if we said "patient advocacy"?

DR. ORNISH: The same thing.

DR. GORDON: So that, Dean, given that, is this okay or how would you reword it?

DR. ORNISH: I would just say that we encourage the public to become more involved in this dialogue or something like that, I mean if we are really not taking a position that we are advocating for CAM per se, but we just want people to get more involved on either side of the debate, then, why don't we just say that.

DR. JONAS: Other comments?

MS. SCOTT: I think the second part of that is important. At least to me, it says this includes the development of, and I think very often as, say, in women's rights in trying to get women involved in health

care decisions, simply putting more women on panels, who don't have a clue about how these institutions and these professions work, is not very helpful.

The development to me says some training of the people who are going to be on these advisory panels, and I think that is an important concept to have in here, that we are not only committed to having representation of the public on these advisory and decisionmaking panels, but that we are also committed to making sure that they receive the kind of training that they need in order to navigate and negotiate and really be powerful spokespersons on those bodies.

DR. ORNISH: But spokespersons for what? That is what I am not clear about.

MS. SCOTT: For the public.

DR. JONAS: For their own interests, for public interest.

MS. SCOTT: For the public interests, not necessarily just for CAM, but just for the public's interests. As someone who sits a lot on these boards, I just don't always talk in favor of whatever the particular subject is, but I really try to look at it

from the angle of whether this is going to protect the safety, encourage the empowerment and partnership with those making health care decisions.

MS. CHANG: I'm sorry. Time check. You have got less than 12 minutes now.

DR. JONAS: We have got several people that want to talk. Joe.

DR. PIZZORNO: Just real quickly, I agree with Dean's concern about that last sentence. It seems like we are creating a kind of a paraprofessional group to go out there being advocates, but I think Julia raised a really valid point, that we want the public to go on the boards, but if they don't understand how the process works, they are not going to be very effective.

So, if this could be changed to something like some kind of training program for people who are involved in those kinds of things, then, I would be in support of this last sentence.

DR. JONAS: I think "development" implies that, and it is not simply training, it is more than that, and "development" is a more general term that would include training. I think perhaps the word "advocate" is the

problem, and maybe we should change that to "representatives."

DR. PIZZORNO: Also, the word "specialist" is a problem, too.

DR. JONAS: Well, if we took out "advocacy specialists," and simply substitute "representatives," it would get more neutral.

Charlotte.

SISTER KERR: This is on No. 7.

DR. GORDON: Let's finish with No. 10 first. I want to make sure we have found something we can live with here. Sorry, Charlotte.

SISTER KERR: That's okay.

DR. FINS: Here is some language here maybe we might think about. Something about we should have informed and empowered, so that implies training, public and consumer representation in research and health care prioritization decisions regarding CAM, because I think the issue of the training would be textual issue, it's not a principle, and how to get to be empowered and informed would be a function of training, which could go into the Education or Public information section.

DR. GORDON: Why not make it just simpler, and use your phrase this includes the development of informed and empowered public representatives, and leave it at that.

DR. FINS: I would say, "Public and consumer."

DR. GORDON: Fine, representatives.

DR. FINS: Okay.

DR. GORDON: Will that work for people?

DR. ORNISH: I still would like, if the intention is to say that these aren't advocate, first of all, I like the idea of changing "advocates or representatives," but to make it clear that to be involved in all aspects of the debate and dialogue surrounding CAM, something like that, so that it is clear that we want people to be involved, not only on just one side or another, but in all aspects of it.

DR. JONAS: Charlotte.

SISTER KERR: No. 7.

DR. GORDON: Are we okay with this?

DR. JONAS: Sorry, Jim, we are out of time.

DR. GORDON: With adding Dean's -- I am not sure what you are adding to it. Incidentally, I am going

to be doing this a lot, I think, and I want all the facilitators to do this, too, as well, we need to focus on specific wording changes, because the less we have to send back to committees, the more we can get decided here, the faster we are going to be able to advance this whole process.

DR. ORNISH: I agree completely with what Jim is saying about the need to get clarity before we move on, so are you accepting my recommendations or not, or how do people feel about it?

DR. JONAS: No, we don't want them.

[Laughter.]

DR. ORNISH: As long as we are clear, that is all I wanted to know.

MR. SWYERS: I think before we leave this two-day meeting, we can revise these and recirculate these for people to look at.

DR. ORNISH: I think rather than doing that, it would be better just to say can we agree with it now, and then we don't have to come back to it.

DR. JONAS: Didn't take out the word "advocates," though, and "specialists," and putting

"representatives" address that? My sense is that that has toned that down.

DR. GORDON: Can we live with that?

DR. JONAS: Advocacy is not there.

DR. GORDON: Dean, can you live with it if we take out the word "advocate" and "specialist," and put "representation and empowerment in education"?

DR. ORNISH: It is certainly a lot better to put representative than advocate, but I mean, why not just say "involved in all aspects of the dialogue surrounding CAM," or something like that. Is there any objection to that just to make it clear that it is not to represent one point of view?

DR. FINS: Representation is not necessarily an advocacy position, it is just that people are represented who are empowered and informed public and consumer. It is a category representation, it is not a position.

DR. ORNISH: That was my first suggestion. Why do we need the second sentence then?

DR. JONAS: So, the phraseology would go, "This includes the development of informed and empowered public and consumer representatives who participate on advisory

councils," et cetera, et cetera.

DR. GORDON: Yes, it is just like participating on the NCI, they want people to be educated, it is not necessarily that they are going to take a particular position on issues.

DR. JONAS: Okay. Charlotte.

SISTER KERR: Am I really going get to speak?

DR. JONAS: Yes.

SISTER KERR: No. 7 goes back to Jim asking us to be very specific. The first sentence, "Good health care requires collaborative teamwork between conventional and complementary practitioners," et cetera, "patients committed to the creation and delivery of optimal healing environments," I am absolutely clear I agree with that.

The last sentence says, "Integrated delivery, however, does not mean the distillation of CAM services that are then offered by conventional practitioners." I am absolutely clear I agree with that.

The two sentences in between, if you could look at those, it says, "Any potential benefits of CAM for the public can best be maximized," and you go on, and the second sentence is, "These collaborations can best be

encouraged by the integrated delivery of CAM and conventional," and also that practitioners working side by side.

I don't know that I agree with that. My feeling is it may be enhanced, it may be, it may be, but it is sort of creating that space for new models to emerge, the traditional healers are not working side by side, but perhaps working in collaboration, but I don't feel a big need if it means physically side by side.

So, I would like to request the group look at that. Could we even, in fact, just do the first sentence and the last sentence, or just have another sentence that says any potential benefits, you know, can be enhanced by collaborative relationships with complementary and conventional, but in fact, I think we say that in the first sentence.

DR. JONAS: I like that idea of cutting out those two sentences and make it more condensed.

DR. GORDON: On that point, I would like to cut out all three of the sentences. I would just like to have the first sentence, which I think sums up the whole thing. I don't know quite what the last sentence means.

SISTER KERR: Oh, I do. I would like to speak to that, Jim. I think we are emphasizing, now, again, we may not want it, that -- I think it is something we have heard over and over during the hearings and within the group, that we don't want to suggest that anybody can just do anything.

DR. JONAS: Or that this isn't simply cherry picking into the conventional community.

SISTER KERR: Was that again, please, Wayne.

DR. JONAS: We are not talking about integrated medicine, we are not talking about simply cherry picking, just kind of putting a few practices into the conventional health care delivery system.

SISTER KERR: It is an area that still shows up, what was the attempt really when we started principles, to say we are talking about, I guess two things, complete systems of healing and also modalities, but, in general, we don't feel CAM is just a modality.

So, I think that is what we are saying here, you can't just take the weekend course and pick up, you know, checking toe reflexes.

DR. GORDON: I understand that point. I don't

know that it is a principle, and this is about partnerships, so it just seems like we are introducing a whole other -- we are throwing in a whole other domain in here, and which doesn't have to do with partnerships.

SISTER KERR: Well, you may have a point there, leader.

DR. GORDON: That is why I would leave it with that first sentence, which I think covers the issue of partnerships.

MR. CHAPPELL: I like Jim's suggestion that we don't comment on the principle in the same breath. I mean, we are just saying what it is we believe in, and we leave it at that, and to delete sentences two and three certainly gets rid of comment.

It doesn't add to anything that hasn't already been said in the first sentence, and I think the only question then is whether you leave the last sentence as a particular sensitivity that those might have to integration or collaborations.

I think it may be worth leaving, but I don't feel strongly feel about it.

DR. GORDON: I would say if we are going to

address that, we ought to have a separate principle which talks about the integrity of systems of healing or something like that, and I am not averse to that, I just don't see it in here. It gets put in, it will raise all kinds of questions, and it doesn't seem to me so much -- that is not the principle, that is sort of a negative thing.

The principle, I think we want the principles to be positive, and the principle has to do with respect for the integrity of systems of healing or something like that.

DR. JONAS: Julia.

MS. SCOTT: I think actually, this is spoken about in the background information, so it is not like we are dropping it, but it is part of the background we have talked about exactly what you are saying, that integration doesn't mean just kind of picking things and throwing them together.

I agree that I don't think it belongs in the Principles.

DR. JONAS: Does everybody agree, then, we should drop all three of those phrases? Joe.

SISTER KERR: I didn't finish my thing, if that's okay. Is this on the 7, Joe?

DR. JONAS: Yes, still on 7.

SISTER KERR: Sorry.

DR. PIZZORNO: I actually really like what Jim said, about a separate principle about respecting the coherency of systems of healing, and that you can't simply cherry pick out therapies and call it CAM or call it integrated.

So, let's remove that fourth sentence from No. 7 and make it a part of a new principle.

DR. JONAS: Comments on that? I am not in favor of creating new principles other than the information which is simply splitting up.

DR. GORDON: Maybe one way to do that would be then to address this more in the text because this is the whole issue of creating a new principle when we have already voted on the principles may not be the world's best idea.

DR. ORNISH: There is nothing wrong with cherry picking some things, I mean, I think there is a whole spectrum where people can get involved in an entirely new

system, or they can just take a few techniques, but to say one is not good, I think is not really representative of what everyone thinks.

SISTER KERR: Isn't it also possible to have that, Jim, that first sentence highlight something of this emphasis? You know, "Good health care requires collaborative teamwork between conventional and complementary respecting" --

DR. GORDON: With respect of each of the traditions.

SISTER KERR: -- distinctions of whole systems, something like -- the writers can do that.

DR. JONAS: That is a good idea.

SISTER KERR: I would like to suggest that is what we do, and this may be one that, in fact, that sentence needs to come back to the group, but, Jim, if you could help us with that.

I would like to make my next comment.

DR. JONAS: Sounds good. Are we finished with this one? We decided that we would add some wording, we would drop the last three sentences in this, and we would add some wording to emphasize respect for complete

systems and this sort of thing.

DR. FINS: I agree with Charlotte's original point about the integrity of systems, and I think that it muddies the partnership point, which is equally important. You know, partnership is important, and so is the integrity of systems, and it seems probably preferable not to muddy the two because it confuses the value we place on partnerships.

In other words, in the same sentence, we are talking about partnerships and integration, and then separateness.

SISTER KERR: It's a relationship.

DR. ORNISH: But if we are talking about an integrated approach to medicine, by definition, you are going to be integrating different systems, and to say that we have to respect those differences, and they have to be considered separately is a catch-22, it's a contradiction.

Certainly, that is not what I think. I mean, I think that you can respect the integrity of the given system, but it is to me like the blind man and the elephant, everybody has a different piece of the

elephant, and if you say, well, that's it, and you can't really merge the two or find common ground, then, I think we are missing the real power of integrative medicine.

DR. GORDON: I am going to urge us to move on, if we can. If we can live with this, we really need to, because we need to finish the discussion of the Principles. I can yield up most of my 15 minutes because it's becoming reasonably clear, but still we only have 10 minutes, given that, and we need to talk about definitions, too.

DR. JONAS: Maybe we will play with that, perhaps even as a second sentence, but rephrasing it in a positive, more respect for all systems, and this type of thing, and we will revisit that again to see if it sounds like it should be there at all.

Any other comments on any other principles?

SISTER KERR: Yes, No. 6. This one has always bothered me. It says, "Emphasis on Prevention," and you will see the revised one, "Good health care emphasizes early intervention and self-care." At the minimum, I would like to put in first place, "emphasizes self-care." My own opinion is primary care is self-care, and we

really need to be saying that more and more often.

I could suggest something like "Good health care emphasizes self-care in addition to the promotion, prevention, and treatment of disease," or, "Good health care emphasizes self-care for the promotion of health care and the prevention and treatment of disease."

DR. FINS: "Primary care" means something really specific in a governmental document.

SISTER KERR: I am not using "primary care," self-care.

DR. FINS: You said self-care is primary here.

DR. ORNISH: It's already in there.

SISTER KERR: That was my own little comment to make the point that is the first level of care is self-care.

DR. ORNISH: But it is in the first sentence. What is wrong with it? I don't get it.

SISTER KERR: I am just saying I am suggesting we put that first.

DR. ORNISH: It is first.

DR. JONAS: She means an emphasis on self-care rather than an emphasis on prevention.

DR. ORNISH: Do you want to say, "Good health care emphasizes self-care and early intervention?"

SISTER KERR: Self-care.

DR. JONAS: In the bolded sections, to say, "an emphasis on self-care rather than prevention.

DR. ORNISH: I don't agree with that.

DR. JONAS: Isn't that what you wanted?

SISTER KERR: Well, no, I guess I hadn't really gotten that far to make that big a jump, but even is we left an emphasis on prevention, I think we should say, "Good health care emphasizes self-care."

DR. JONAS: Doing it before early intervention.

SISTER KERR: Yes. We don't use the word in this particular editing, we don't even have health promotion, promotion of health, so the suggestion was do we want to say, "Good health care emphasizes self-care," period, or comma, "in addition to health promotion, prevention, and treatment of disease."

DR. JONAS: Adding "health promotion?"

SISTER KERR: Yes.

DR. ORNISH: I would add "health promotion" to that.

DR. JONAS: I would, too.

SISTER KERR: Self-care and health promotion is where I think our edge is on what we are trying to re-create in healing.

Actually, back to what Wayne said, I don't know that is a true statement, I mean, to begin with an emphasis of prevention, I don't know if we do want to call that the principle. It is like that is not what I am saying.

DR. JONAS: That is what we have been calling it.

DR. ORNISH: I really think we are splitting hairs here. We have got a whole section to talk about, and whether it is self-care and early intervention, or early intervention and self-care, I think is not really worth spending a lot of time on.

DR. JONAS: The question is should we use "promotion" rather than "prevention," is that correct?

DR. ORNISH: I would use both.

SISTER KERR: We were asked for us to get specific, Dean, and I think that is what we are trying to do.

DR. JONAS: Go ahead, Effie.

DR. CHOW: I really go with what Charlotte was saying, because health promotion is positive, disease prevention is still operating on the negative, a fear of getting something, and self-care, then health promotion, and then prevention is in that order. I think it really is important.

DR. JONAS: Tom.

MR. CHAPPELL: I don't want to lose the idea of self-care, however. Self-care embraces prevention and treatment, both.

DR. JONAS: I don't think we are going to eliminate that.

DR. GORDON: I would like us to move ahead and get a clear sense at this point of something we can live with.

DR. FINS: The second sentence, I don't think is factually true.

DR. JONAS: I was going to get to that in a minute. Are we finished with the phraseology of the first sentence, that we are going to put self-care and health promotion upfront, so it will be, "Good health

emphasizes self-care, health promotion, and early intervention for maintaining health and preventing disease," or "maintaining wellness and preventing disease"?

DR. FINS: Or delaying disease, because you don't always prevent disease, and you don't want people to think if they engage in all these things, they will never get sick.

The second line here is that with the exception of like things like pneumococcal vaccines, it really hadn't been proven conclusively that prevention saves money, and some people say all you do is engender additional costs because people get diagnosed earlier and there is more intervening care, so it is an interesting argument from the Brookings Institute, so I don't think the second sentence needs to be there. It is more of a justification, and for parallel structure, we have not tended to justify the principles.

DR. JONAS: So, should we eliminate the second sentence?

DR. ORNISH: Just say "often" instead of saying -- you can say, "There is scientific evidence that is

often more humane and cost effective to prevent illness," and that is a true statement.

DR. JONAS: So, eliminate "overwhelming"?

DR. ORNISH: Eliminate "overwhelming," and just say, "There is credible scientific evidence that is often more humane and cost effective to prevent illness and disease compared to" -- blah, blah, blah.

SISTER KERR: I agree.

DR. JONAS: Go ahead.

DR. LOW DOG: I guess if we are trying to keep formatting also, is that a principle? I mean, I agree with the statement, I agree with it, I am just not sure that is a guiding principle.

We are trying now to go through and say what our guiding principles are. I am not sure you need to justify it.

DR. JONAS: So, again, a suggestion that that be eliminated because it is not actually a principle, it is more like the three sentences we eliminated in No. 7.

MR. CHAPPELL: It's a comment.

DR. JONAS: It's a qualification and comment.

MR. CHAPPELL: I am for taking it out.

DR. JONAS: So, everyone agree that we should take that sentence out?

[No response.]

DR. JONAS: Any other comments on any of the other principles?

DR. BERNIER: We are keeping No. 6?

DR. JONAS: Yes, we are keeping 6 with the modifications that I mentioned.

Effie.

DR. CHOW: On the whole, these guiding principles, you know, being that people have a very short time to read everything, I would suggest putting, under each one, a reference point like "See pages such and such for clarification," so that they don't have to look through the whole thing and say, well, where does this come in.

MR. CHAPPELL: I don't agree. I want to speak differently on that. Beliefs are the composite of this group here, and they just stand as they are, they stand alone. They are what we believe. I don't think it needs to be referenced to be built. They are the summation of what we believe, having been through this whole process,

and I think the should stand on their own.

DR. JONAS: Tieraona, and then Jim.

DR. LOW DOG: I just think it would also be difficult as much of this is woven throughout the entire document, that it would be difficult to reference.

DR. GORDON: Two points. One is I would agree with that. I think it is too much to try to reference. It will become clear if we do our work properly.

The other thing is we have five minutes left. We have not dealt with area of definitions at all. We have to make a decision about what to do. I can summarize in three to five minutes.

That's fine what we have done so far, but we need a decision about how we are going to proceed. Tom, do you have thoughts about it? I think this section we have done well with, but a little slowly, and we have to take heed for the future, and I am really going to put more and more of this on the facilitators.

You have got to move everyone along as quickly as possible. I will help, but the process needs to move forward.

MR. CHAPPELL: I think, in the interest of

time, we can just look at the bodies of the sections and just ask if Commissioners have any particular build, that they would like to see more emphasis here, or less emphasis, but leave the work to the committee, and you can do what you need to do to find consensus, but I don't think we have the time to go through this the way we have just done the Guiding Principles.

I will do my best to move us through quickly, Jim.

Yes, Dean.

DR. ORNISH: I am sure this isn't going to be a popular thing to say, but I have some real concerns about this whole section.

I don't know if I am alone in these feelings or not, but I mean, first of all, the beginning part, the common characteristics of CAM systems is so redundant with what we just did, that I am not sure it is worth repeating it again, but the whole history of CAM is written from the point of view of the voice of somebody who feels wronged, you know, a CAM practitioner who is saying, you know, kind of relaying the whole gripe about how they have been treated unfairly, and if we are trying

not to -- I mean, if we are going to do that intentionally, fine, but I think we should have some awareness that that is how it reads to somebody. It certainly reads that way to me as an advocacy and kind of a justification of how wronged people have been in the past.

DR. GORDON: Dean, thank you. Let me make a suggestion, Tom, that you take 10 minutes here to surface these kinds of major concerns, that we not worry about the specifics as much as about the kind of issue that Dean is raising.

MR. CHAPPELL: I would like to do that, but I also need to bring some introductory comments to this whole section as a facilitator. Then, I would like to do that.

DR. GORDON: Why don't you do that.

MR. CHAPPELL: I think what we have in this Section 6 then is a definition of CAM, we have a description of CAM, we have a history of the evolution of CAM, and then we have some description of the collaboration barriers to CAM and traditional medicine.

So, what I found, first of all, the definition

we have been working on all along, and it is not easy to come up with a definition, so I think we have got the best we have seen.

On the history, I really appreciate the suggestion of those of you who wanted the history, because, for me, I think we can accomplish the history with some editing without having a pejorative tone on any of the communities, any of the medical systems, and I think that is the way the history needs to be developed is without pejorative.

But what the history does show that I think is very, very important is the evolution of a mature system. It begins with the marketplace, it moves next to the formation of a professional society. That professional society works with an educational institution.

Research monies are used to help make discoveries, and then the government gets involved, and then you have a mature system. If you look at what happened of the American Medical Association versus the Homeopathic Association, one had its strategy right, and the other really didn't get it.

Now, that doesn't mean that any of these

systems is any less efficacious. It means that one system developed a strategy that made sense to consumers and to the government, and it acquired dollars behind it to drive it educationally and in terms of research.

So, I think the history can be done in such a way that we show how systems evolve in their mature cycle, and then do away with the pejoratives on any group.

That is what I liked about that, and I think having it in here is essential. So, let's open it up.

Joe.

DR. FINS: I agree. I think history is very important. I would like to offer a slightly different formulation based on the work of a medical historian named Paul Edelson, and he talks about the place of William Osler in the rise of modern medicine, the first real internist.

He wrote his Textbook of Internal Medicine in 1892, and the brilliance of Osler's textbook was that its focus was on diagnosis, and not on therapeutics. In the latter half of the 19th century, there was absolute chaos in people recommending things that didn't work, and

people didn't even know the diagnosis for which they were recommending things therapeutically.

Osler was able to have a kind of hegemony in medical thinking that was strong and pervasive, because he did not focus on therapeutics. The Flexner Report is sort of the systematic outgrowth of Oslerian medicine, you know, focused on diagnosis. I mean, Osler was often described as a therapeutic nihilist. He diagnosed, and then there wasn't much to do.

It was based on diagnoses that these new therapies came forward, the antibiotic era, and the like, and the rise of the governmental involvement.

Jim, our own Jim Gordon, wrote a paper last year about the Flexner Report revisited, and I think we could cast it positively by saying the CAM movement has come back in a way after the allopathic movement has made all this diagnostic and therapeutic progress, and it is the second wave.

I mean, Jim did this, so you could have Paul Edelson's paper, talk about Osler, the Flexner Report, which I think was a milestone and dramatic and an exceedingly important part of our development of our

health care system, and cast it positively as a next wave, and not the antagonism, phrases like the battle lines had clearly been drawn aren't really good. This is a historical evolution, and I think it shows that there is a maturity in our system that allows the CAM system to be reintegrated now, after a 100-year hiatus, in a way that is synergistic and not antagonistic. That is how I would cast it.

MR. CHAPPELL: Thanks very much.

Other concerns about any part of this section? Yes, Bill.

DR. FAIR: Well, I agree somewhat with Dean, and we should avoid pejorative terms as much as possible, but under the whole systems, on page 2, this, I take objection to. I don't think a complete systems means a chiropractor offering information on diet, breathing, relaxation. I don't believe that a physician or a chiropractor, for the most part, is as adequately trained as opposed to a dietician for providing this kind of information.

The same thing, I don't think that an M.D. or a chiropractor that takes 300 hours of training and a

license in New York as an acupuncturist is as well trained for acupuncture or traditional Chinese medicine as someone that spends 4,000 hours in a formal program.

So, I mean, the implication here is to me, that because you are a CAM practitioner, you are a master of all arts, and we are getting back to general practice of CAM, much as we are moving away from the general practice of medicine.

So, I would be more happy with this if the complete system meant that the appropriate experts were involved, not just one person that happened to fit under the CAM rubric. I would expect a cardiac surgeon or urologist to be giving advice on diets, and so forth, and so on, nor would I expect a chiropractor.

DR. GORDON: Bill, could you summarize that in one sentence what your critique is?

DR. FAIR: Critique is to use the people that have the most training in that particular specialty.

DR. GORDON: So, you are saying you think the language is too loose in describing people's scopes of professionalism?

DR. FAIR: It gives the impression, when I read