that, is because you are a chiropractor -- and I am not picking on, I mean, it could be anything, it could be an M.D. -- in addition to providing spinal adjustment, may also offer advice on diet and exercise, breathing and relaxation, and nutrition supplements, the implication is that that chiropractor is an expert in those areas, and I don't necessarily --

DR. GORDON: Is it that or that it is simply a description of what is happening?

DR. FAIR: Well, I don't think it should happen.

DR. GORDON: But it is what is happening.

DR. FAIR: But that is not necessarily a whole system. A whole system is much like a tumor board or something like that in allopathic medicine, where you get experts in various disciplines.

DR. GORDON: I understand. I am saying these sections are descriptive, not prescriptive, I think. Isn't that right?

MR. CHAPPELL: That's correct, that is all it is intended to be.

DR. FAIR: Well, maybe it just hit me the wrong

way, but I had the impression that was given here is you are saying that that is a model to be emulated.

DR. ORNISH: It is implicit in there.

MR. CHAPPELL: I think we can fix this language to be sure that it is descriptive, and not prescriptive. I think that is a good recommendation.

Veronica.

DR. GUTIERREZ: I would like to respond to Dr. Fair. I agree totally with what he said. The chiropractor practices within a whole system, and that reference is to the nerve system. The addendum about may also offer advice on diet, exercise, et cetera, those things are happening, but they don't relate to whole systems, and I have no problem with eliminating that.

There are some chiropractors who choose to go as far as diplomate status in nutrition, and they are definitely experts, but that is not the whole system concept that is being addressed here.

My comment that I would like to make to this section is I don't want the terminology that we have discussed at previous meetings to be lost, and under Current Status, I would like us to pursue that now may be

the appropriate time to change some vocabulary, and we have talked about collaborative and integrative healing or collaborative and integrative health care, but I would definitely like to see the discussion begin on changing the term "CAM" to something that is more appropriate.

MR. CHAPPELL: Thank you very much, Veronica.

Tieraona.

DR. LOW DOG: I would second that, whole systems, I thought the examples were just not appropriate examples. I understand what we are trying to say by "whole systems," I just, one, when you are talking about a system of medicine, and then you use isolation of extracts when you are talking about an herb, it doesn't fit within what you are trying to say about whole systems.

Also, just when I am reading through here, when we have the similarities amongst major CAM systems, and then we get to under Stimulating Self-Healing Processes, and we say things like "have adopted the philosophy that the body's self-healing mechanism can be speeded up sometimes to an astonishing degree," I think we want to be careful to leave out those kinds of phrases.

I think what we are talking about is what their similarities are. Here, you are making a judgment call on the fact that it actually does. I think some of those things remain to be seen.

MR. CHAPPELL: Agree. Thank you.

Joe.

DR. FINS: I think it might be helpful to distinguish therapies and systems, because I think that Table 1, if you look at it, is both, and there are things that are whole systems of care, and there are other things which are elements of multiple systems of care, and they would have different levels of evolution and sophistication.

One would be an entire paradigm, and one would be a modality. So, somehow I think it gets kind of clumped together in the chart, and it gets clumped together in our common characteristics.

So, I would like maybe to say again we have addressed this before as a group, and we got into trouble because we were trying to label it and do a taxonomy of the various things, could be perceived as prejudicial, but I think it might be helpful to say there are

modalities, there are therapies, there are systems.

Traditional Chinese medicine is a system with multiple thousand-year history.

DR. GORDON: Excuse me. I am going to ask that each person make their point briefly and then we go on. What we are looking to do is to give them what they need to proceed.

MR. CHAPPELL: Ming.

DR. TIAN: I think for the whole systems, for example, a chiropractor can do this and that. That, I got confused. Are we supporting this kind of situation? If that is the truth, it is happening in the real world, but again, as this commission, we should not suggest people learn each other, and we don't need a license. Can I teach you exercise? Sure. Are you a professional to teach the rehab exercises for patients? You are not.

MR. CHAPPELL: So, you want to see the specialty acknowledged as a part of a whole system, not that this practitioner is in charge of the whole system.

DR. TIAN: Yes, I have a feeling that we are encouraging people learn each other, just learn information, you are not cross the line. I am not a

chiropractor. When I so acupuncture, can I do adjusting your spine? That is out of my scope.

DR. GORDON: This is a descriptive section. I would like to come back to the guidance, the specific guidance that they need. Then, in three minutes, we have to decide what the next step is going to be, how you all are going to work with us to come up with the next iteration.2

DR. TIAN: Again, I think we should revise. Thank you.

MR. CHAPPELL: Thank you.

We are going to go to the definition at this point, just to be sure we have captured your feelings on that.

Joe, did you have a comment before we go there?

DR. PIZZORNO: Two points. First, Joe, I think you made a really good presentation about the clinical and academic side, about the advancement of medicine, but you ignored the political side of the advancement of medicine. When Osler was doing his good work, the Flexner Report ditched* all of the non-pharmaceutical-based institutions, and in Fischbein [ph], used that

information and defined the head of the Ishpath [ph] of Medicine as Public Enemy No. 1, and then used that to politically suppress the other healing arts.

I want to say we have some agreement here, but I think there needs to be a part here which talks about the advancement of medicine becoming more effective, but what it says here about the political part actually is still missing many pieces.

I have to emphasize right now in at least 14 states, the local state medical associations are blocking the license of other natural medicine practitioners, so this is a reality. It is still happening today. Political repression is real. We can't ignore it.

DR. FAIR: Tom, I will put on my surgeon's hat. Cut out the last sentence.

MR. CHAPPELL: Of whole systems?

DR. FAIR: Yes. Why do you have to use an example of a chiropractor?

MR. CHAPPELL: So done. Thank you.

Now, on the definition of CAM, page 1.

DR. GORDON: I have a general comment on some of the subsections. I don't think the definitions are as

good as they could be, particularly on energy medicines, spirituality --

MR. CHAPPELL: Jim, I need clarification of your comment. We are talking about the single paragraph on page 1.

DR. GORDON: No, I was talking about underneath there where you are defining the specific -- presumable under D and E, there is no definition of energy or spirituality. I'm sorry, I was not addressing that first paragraph.

DR. JONAS: Those are not definitions. Those are just descriptions of some characteristics.

MR. CHAPPELL: We had to distinguish between definition and description.

DR. GORDON: I think there has got to be -- what I am suggesting is there needs to be more information for people to understand what we are talking about.

MR. CHAPPELL: On energy and which one?

DR. GORDON: Spirituality.

MR. CHAPPELL: Thank you.

Other comments on the definition paragraph?

Yes, Ming.

DR. TIAN: Can we make this definition shorter?

MR. CHAPPELL: And your direction on how to do that is?

DR. TIAN: I don't know how to do it.

MR. CHAPPELL: I see.

DR. TIAN: I am confused.

MR. CHAPPELL: Thank you, Ming.

DR. GORDON: I think it's pretty good actually, that first paragraph, so I will just share that with you.

MR. CHAPPELL: I don't hear any burning desires from the Commissioners on that paragraph. We move into the description. I'm sorry Dean is not here to comment further on what he found redundant in this section, but I do think if we are going to introduce CAM, certainly in a Definition and Description section, we have got to talk about the common areas here, so I really think we need to have those.

We have had enough discussion about the History section. I think if we could look at page 14, the collaboration section --

DR. GORDON: I would like, before that, Tom, to

make a point that on page 13, I think the whole notions of holism and of holistic approach or integrated approach needs to be discussed, not just complementary or alternative, and that that may help, especially on page 13, may be the place to do it.

I think that that is one of the major advances that has come in the last 30 years, as we are sort of looking at what we need to do, what the next step in medicine is. It is really that focus on holism and integration.

MR. CHAPPELL: Good. Thank you, Jim.

Yes, Joe.

DR. FINS: This might be a nice place to drop in the Ven diagram, the separate and integrated, Charlotte's point about the integrity of systems. I mean, you could have an integrity -- I think the point is you can have an intact integral system that overlaps through the patient with another system.

You could practice your art and still collaborate without contaminating each other, and this, I think would be a great place upfront for Charlotte's point.

MR. CHAPPELL: There seems to be agreement on that, thank you.

Jim.

DR. GORDON: I just have one more, another specific. On page 15, at the top, one of the integrative models of health care, I am not sure why that particular example is there or that it is necessarily the best example, and if you are going to give the example of practitioners practicing side by side, why is it promising? I think it is just stated here, we don't have a description.

The top of page 15, one of the integrative models of health care that is being pilot-tested. If we are going to make this kind of statement, we need to give some substance to it and say why it is or might be promising.

MR. CHAPPELL: Do you think that it is helpful to have the example which does describe the -- I mean, it's representative of the difficulties of collaborations, you would just like to see something --

DR. GORDON: I think it's fine to talk about the difficulty, but we have specifics about the

difficulties, but nothing specific about the collaboration.

MR. CHAPPELL: Oh, about the collaboration.

DR. GORDON: So, it is kind of an imbalance, so let's talk about the collaboration and then, in that context, we can talk about some of the difficulties.

I am not sure it belongs here, and I am sort of saying if you talk more generally about holistic or integrative approaches and just mention, describes some of what is happening, then, it may not be appropriate to have this kind of specific example at this point.

It may come better under, for example, Access and Delivery to be talked about at greater length.

MR. CHAPPELL: Thank you.

Joe.

DR. FINS: I agree. I think giving a specific example trivializes the point, and we could take William Errol's place, we could take Bastyr, I mean, there are lots of places that could be mentioned here that have different kinds of collaborations. I think having a single example weakens it.

SISTER KERR: This may be discounted, but as

one example also, Prince Charles, I believe just recently is funding the first integrated hospital in London. That is an example if we want an international model.

MR. CHAPPELL: Thank you.

Bill.

DR. FAIR: I will just make a plug for our own system basically. In our system, we have no physicians other than myself, and it is not working side by side, but within the first six months of our existence, 10 percent of our referrals are coming from physicians.

Medical oncologists, for instance, or radiation therapists love to still be in the loop, even though they are not side by side, but they are getting the input from all of our specialists in the various areas.

I personally think that a CAM doctor is basically a GP. What we want to do is keep -- I think every doctor should be a CAM doctor, and I think that whether it is a heart surgeon or a medical oncologist or whatever, I think they have to be in the loop.

I don't think the best care requires that they are working side by side with complementary medical people, it is just that they are brought into the

process.

DR. GORDON: Tom, I would like to close here and pose the question what do you need and then what do we need as a group to take this section to the next level?

MR. CHAPPELL: I think one thing I need is to know whether you want no examples or three examples in this section, because one isn't working, and I would prefer that we have three different models, if you will, of collaboration because that shows the history, this is a History section, and it is a Description section.

We have heard of different models. There is the university hospital, there is the entrepreneurial clinic, there are different models here, and we could give examples generically of those models, of collaborations.

Yes, Joe.

DR. FINS: Also, maybe a research collaboration model.

MR. CHAPPELL: Yes.

DR. GORDON: The broader question is what do you need from the group. If they are interested in

having models of collaboration, that is kind of specific. What do you need to take this chapter to the next level? You have heard the suggestions and the critiques from the group. Would you like more input from some of the members here?

What we need, and I don't know what the exact timetable is, but very quickly, I think we need to have another version of this section to meet some of the concerns that have been raised here.

MR. CHAPPELL: I do, too, and I think it is something that Group H and Jim can work on immediately. I think we could spend 10 days of dialogue and edits, and then circulate this Section 6, addressing these concerns.

MR. SWYERS: Since we have had such little time to focus on this section, if people could focus on this section and send us their laundry lists of problems and suggestions for this section in the very near future, just go through it and just make an informal list of things that you think need to be added or deleted, then we can get all those in and see where the areas of common agreement are, where there is some disagreement. That will help us dramatically in doing the next draft.

DR. GORDON: When do you think you could have a next draft to send back to us?

MR. CHAPPELL: I would like to comment on Jim's suggestion. I don't want to get a laundry list from you. I want specific suggestions to the specific concerns that have been raised here, because that is the only way we can be focused and directional.

You have heard, for instance, that there is some question about how we handled the History section, and we have had some other comments. I am talking now just about the definition and history description, and so forth.

I would like to have 10 days of committee time, frankly, how about you, Jim?

MR. SWYERS: Two.

MR. CHAPPELL: Two days or two weeks?

MR. SWYERS: Two days.

MR. CHAPPELL: Really.

MR. SWYERS: I think actually, when we meet next time, we will have to spend more time on these sections.

MR. CHAPPELL: I think the expectation is that

we can't let this go until the next meeting.

MR. SWYERS: How much time do we need before we can --

MR. CHAPPELL: Circulate a revision.

MR. SWYERS: I think we are going to need two weeks at least.

DR. GORDON: Fine. My suggestion is that everybody who has specific suggestions for Tom and for this group, get it back by next Wednesday.

MR. CHAPPELL: Okay.

DR. GORDON: That then we get a document in two weeks that gets sent around so we can then see where we are. I agree with Jim Swyers, we will have some time. This is a wording document rather than a recommendation document, and we will have more time to go over it next time.

MR. CHAPPELL: Thank you.

George.

DR. BERNIER: I would just like to comment that, like Joe, I feel very concerned about the general tone of this whole section, and it is really setting up an adversarial relationship.

DR. GORDON: I agree with you, and my sense is that Tom and Wayne have heard this very clearly, and that that is the general feeling of many people here.

On this section, on the Definition section and the History section, I think the Commission's concerns are clear. If there are others, please get them to Tom and to Wayne before next Wednesday. They will have back another document to us, and we will have another opportunity to go over it to meet those concerns.

Session Summary

On the earlier section, let me just review some of the things that we have agreed on, because I think we did come to a pretty good consensus. We need to sharpen some of the examples, we need references. The history needs to be interwoven, but balanced.

There is an understanding that this field is integrative, that patients move among various systems of health care, that a Ven diagram will help to illustrate the situation in which the field finds itself; that we need to indicate clearly that for some of these approaches, there is good evidence, and for others there is not.

When it comes to the Principles, on Principle No. 9, we have split out the second part and made that a principle about information. On No. 10, we have made a specific change by taking out the public advocacy specialist and putting in a wording having to do with representation and education of the public.

On No. 7, we have taken out all the but the first sentence, and there will be at least a phrase in there about respect for various healing partnerships.

On No. 6, there is an emphasis on self-care and health promotion coming at the beginning before early intervention.

Back to the Definition section, the concerns were the pejorative tone, differentiating between description, and not prescription, in our discussion, that we are not saying this is the way it should be, we are describing what is actually going on; that there be a recognition of holism and integration, that when we are talking, that there be some in some of the areas of definition, that there be some more specific information so people will understand some of these areas, particularly ones that are somewhat unfamiliar, and that

we want to talk generically about models of collaboration rather than using specific examples.

The History section, yes, that the pejorative tone be taken out, and that the History section reflect a balanced perspective as people have articulated on what has happened.

DR. JONAS: And it also remains accurate.

DR. GORDON: And also accurate.

Tieraona, anything else that I missed?

DR. LOW DOG: No, just but when you are talking about accurate, of you are going to have whole truths, then, we have nothing in there about a lot of the fraudulent quackery that was going on what was CAM at that time either, there is none of that.

DR. GORDON: I think that may well be an appropriate thing to put in there, as well. I think that we can provide that perspective.

MS. LARSON: This will be I think the tenth time I have said this. This is excellently covered in Roy Horter's History of Medicine book.

DR. GORDON: We have just shortened our lunch. Let's take a 15-minute break and then we will come back

and begin with the next section.

DR. GROFT: Let me make just a few announcements real quick. If you have a yellow folder at your place, sign and return it. Mandy Stoneberger is here with Mary Plummer from Committee Management, that we need it.

We will have a group picture at noontime, so we hope that you will be around, and I just want to mention Bill Harlan is here. He was instrumental in getting this Commission established a couple years ago when he was acting director of NCCAM. So Bill is over in the corner here if any of you would like to say hello.

[Applause.]

[Recess.]

DR. GORDON: This next presentation is Education and Training of Health Care Practitioners, and George Bernier and Joe Pizzorno will be conducting the session.

Discussion Session II: Education and Training of Health Care Practitioners

DR. BERNIER: Good morning. Since our last meeting of the group on medical education met, we have

really undertaken a major number of changes in our document, and I would just like to read that to you to start with.

At the October 4 through 6 meeting, we were asked to propose demonstration projects for the area, merge Draft Recommendations Nos. 29 and 30, refer essentially all 12 draft recommendations presented at the October meeting with the meeting with the workgroup, and we were asked to provide more specificity and detail.

Those were the requests we had. What we did was to have a workgroup conference call on the 9th of November, had a follow-up conference call on the 12th of November with Joe, Steve, and myself, revised the draft recommendations and text based on notes from discussion, the Chairman's summary and transcripts from the October meeting, and produced a new set of draft recommendations and test by the middle of November.

What we actually accomplished was we have proposed demonstration projects, we have merged the Draft Recommendations Nos. 29 and 30, and rewrote Issue No. 6. We also rewrote Issue No. 3. We provided specificity and detail in the text, and not in the draft recommendations.

We have expanded background text, and we revised and refined the draft recommendations.

What Joe and I would like to do now is just to show you the revised edition. The first recommendation is that, "The Commission recommends the --

DR. GORDON: Excuse me, George. The format is to ask if there are any gap recommendations that anyone has, so you will be able to allot some time at the end to those gap recommendations.

DR. BERNIER: Yes.

DR. GORDON: You don't have to state them. Do you have a gap recommendation? I have one. I don't know if anyone else has any. I just wanted to let you know that.

DR. PIZZORNO: Would you define the term "gap"?

DR. GORDON: A gap is the emptiness between two holes.

[Laughter.]

DR. GORDON: No. No, a gap is anything, a recommendation that addresses issues that either were present in the October 4th or 5th that seemed to have been dropped out or obscured, or an area that is of

particular interest and importance, especially of particular interest and importance that may have been left out altogether.

That is a gap recommendation as opposed to a revision of the recommendations that you already have. I have one.

DR. BERNIER: Tieraona, do you have a gap recommendation?

DR. LOW DOG: No.

DR. BERNIER: Then, it's not your turn to talk.

Jim.

DR. GORDON: The gap recommendation will come at the end. You will come back to me at the end, after you have gone through your recommendations.

DR. PIZZORNO: I thought you said we would do it now.

DR. GORDON: No, no. All I am saying is to notify you that at the end of your presentation, there will be one more recommendation for discussion, and we will do this at the beginning of all the presentations, so if there are other gap recommendations, you will so signal at the beginning of the presentation, and then we

will address them at the end.

DR. BERNIER: So, is it all right if I go ahead? "The Commission recommends that appropriate support should be made available through competitive award processes for CAM faculty, curricula, and program development at accredited CAM and conventional institutions."

Comment? Yes, ma'am.

DR. LOW DOG: It is more in the background. Is that allowed?

DR. GORDON: A little.

DR. LOW DOG: Well, no, because this is what we have done in the other places. It's again talking about when we have got the majority of support. Like on page 3, the majority of support from NCCAM has been given to conventional institutions during Fiscal Year 2000, the only CAM institutions. I'm just curious how many applied, and what were the reasons for that. Maybe those were the only ones that applied. Maybe some of the rest were stinkers.

I mean, what does that really mean? There is this implied feeling that we are rejecting them out of

hand because they are CAM institutions, and I just don't know, personally, if it's true or not.

DR. GORDON: Let me just begin by trying to clarify something. What you are saying, you are not commenting on the recommendation, you are commenting on some of the text, out of which the recommendation seems to come. Okay.

DR. PIZZORNO: Thank you for that perfect entre to what I wanted to say.

A concern I have is that, on the one hand, we recognize, I believe, the need to advance CAM education and research, clearly important. On the other hand, we don't want to be seen as detracting from conventional medicine education and research, which is important.

One of the ways we resolved that was by saying, well, let's have competitive processes. Well, the problem is that is not a level playing field. It is not a level playing field because beginning around 50 years ago, the federal government started putting a huge amount of resources into conventional medicine, which established an infrastructure for education for research and for grant applications that is not present in the CAM

world.

So, you have got the question about the 97 percent. That is real, and I know that at Bastyr University, where my only debt is, we submit a lot of grant applications. However, our ratings vary all over the place, and I think that is because, one, we don't have as much skill as conventional medicine. The second is because we are asking questions that are different from what conventional medicine is comfortable with resolving.

For example, we want to look at multifactorial interventions in various conditions, and that immediately downrates our grant proposals because it is not for single intervention trials.

So, as I look at this language, I feel very strongly that we need some kind of either affirmative action for CAM institutions or maybe, say, for a period of time we separate out a chunk of money for a CAM institution that they compete with each other for and grow that way, and a chunk of money that is competed for by both conventional and by CAM.

But we need to have some kind of affirmative

action here, because right now we say we want to be equal and fair, but the reality is it's a 100-yard dash, and the medical profession is already at the 50-yard line.

DR. BERNIER: Joe.

DR. FINS: On the allopathic side, I mean, not all allopathic practitioners or investigators get NIH grants. I mean, that is the top of the ladder of the food chain, and people get funding from family foundations and large-scale foundations, and there is an evolution here, and I don't think it is probably appropriate for people who are novice investigators to get NIH funding, because it's a meritocracy and their rating.

I mean, it is probably true of Cornell, as well, but our investigators get a heterogeneity of ratings, some are competitive and some are not. So, I don't think that is unique. I think it is a qualitative assessment.

DR. GORDON: Joe, is there a kind of change in tone that you are suggesting here?

DR. FINS: This is by way of background material.

DR. GORDON: I know, I understand, and I appreciate it, but I am also mindful of the time.

DR. FINS: I just want to echo Tieraona's point that it sounds like it is discriminatory versus discriminating, you know.

DR. PIZZORNO: It's discriminatory. It is discriminating and discriminatory. It is discriminatory because it should be, but it is also discriminating because do not start at the same place.

DR. LOW DOG: Mine was really a question, and that still hasn't been answered. I am hearing points of views, but what I asked was only these CAM institutions, these were the only ones that were granted, how many applied.

So, to me, that is saying the only CAM institutions, that is meaningless to me, because I don't know how many applied. Maybe they were the only ones who did. I believe that there is probably an unequal playing field, I believe that to be true, however, what I am saying, in a document such as this, is when you say the "only CAM institutions," but you don't give any sort of number, out of how many, and why.

I think there needs to be more information there. It again comes back to setting the tone of the document, that you want to come across, not as being biased, but just presenting the facts.

DR. BERNIER: I would guess you could probably say something like it is a growing discipline within the CAM schools.

Joe.

DR. KACZMARCZYK: Since I wrote that, I will take that as a request for the numerator data, and if there are numerator data available, they will be included.

DR. GORDON: For me, there is a more general question. I think the whole section has to be -- there needs to be a statement of the problem, why faculty development is important everywhere, and then perhaps this may be a way to handle it, why it may be particularly important right now at CAM institutions, as well as for people who are study CAM approaches in conventional institutions.

So, I think a little bit of that framework will help the section, and will take away from this pejorative

sense that people have.

DR. BERNIER: Great. Thanks, Jim.

DR. FAIR: George?

DR. BERNIER: Yes, Bill.

DR. FAIR: I think the term CAM and conventional institutions is too narrow, and I would vote to eliminate that. I think Joe is right on giving us the quantitative data. This reminds me very much of the arguments that went on 15 years ago about whether M.D.'s or Ph.D.'s got the bulk of the funding through the NIH, and it was the Ph.D.'s in medical school faculties, as most of you know.

On the other hand, if we look at the advances, I mean, let's face it, we haven't gone very far in research in CAM, and what we need to do, I think, is to bring in specialists from other disciplines.

If you look at ultrasound, if someone would have said in 1930 that by the end of 50 years, we would be using ultrasound to diagnose and treat diseases, he or she would be laughed off the podium, because we didn't know what ultrasound was.

When we got the particle physicists involved in

diagnosis, most of these people were working for defense contractors, for sonar, that is where ultrasound started, and that is not a CAM institution or conventional institution, it's a private group.

The stuff that Dean is doing, ultrasound in the prostate --

DR. GORDON: Bill, I'm sorry. Could you give us some wording that would enlarge it then?

DR. FAIR: Well, I would cut out CAM and conventional institutions, and I would just say -- I can work on some wording -- but what I am getting back to is my favorite shtick, and that is, we need to get something like a SPORE, we need to make it attractive to bring in particle physicists and whoever else is out there that can help us, and that will -- you know, the rising tide floats all boats -- it will help the CAM practitioners, it will help the conventional practitioners, and it will bring in this infusion of new ideas and new approaches to CAM therapies.

DR. BERNIER: Thanks, Bill.

Joe.

DR. FINS: I would just echo what Bill said,

and maybe leave it as it is, and say, "and foster their collaboration," because we did have a discussion previously that the synergism -- and maybe it's not discriminatory that these major academic centers were getting funding, and that Bastyr that collaborates with Washington gets funded, maybe there is a phenomenon here that for a CAM institution to be competitive, it needs to collaborate with a brother or sister university in a synergistic way to get NIH funding.

So, I think we want to foster their collaborative grant applications, because that allows for a local transfer of talent in both directions.

So, I think that should be one of the principles here.

DR. BERNIER: That had been one of them.

DR. FINS: We lost it.

DR. BERNIER: Yes.

DR. GORDON: I want to say two things. One is on the topic, and the other is more generally. On the topic, I think we need to foster both independent work and also collaborative work. I don't think we should force people to collaborate.

On the more generally, we need to be mindful of time and we need specific wording, so, Bill, if you have specific wording or you want to propose specific wording, we really need to do it now, so that we can leave here with as many recommendations as possible just the way we want them.

DR. BERNIER: So, would you repeat it, Bill, what you had proposed?

DR. FAIR: I forgot already. It is the idea of bringing other people in the field. Energy medicine is not going to be solved by allopathic practitioners or CAM practitioners, it is going to require other specialists, i.e., particularly physicists, and something like that, but I will put something down and have it to you this afternoon.

DR. GORDON: Before this hour is up and ideally, within the next 15 seconds. I don't mean to be cute about it, but if we don't do it, then, we have to come back to everything at the end. I want to settle it now.

DR. FAIR: Before the hour is up, okay.

DR. GORDON: No, I actually want to settle it

before the 15 seconds are up if possible, because otherwise, we have to come back to everything at the end of the hour, if you follow what I am saying, if we do this pattern.

DR. FINS: To address Bill's point, and, Bill, tell me if this would just deal with it, "and foster their collaboration."

DR. PIZZORNO: That is in the next recommendation.

DR. FINS: No, Issue No. 1, this is on Issue No. 1.

DR. PIZZORNO: But it's in the next recommendation.

DR. FINS: Okay, I'm sorry. My second point was on line 57 to 59, another rationale for faculty development resources, would it be to give CAM faculties the background in allopathic medicine that would allow them to train their students in the basics of the conventional health care system. It's just another justification.

DR. GORDON: Let me just suggest that No. 43 is okay as it stands, because conventional institution could

be departments of physics, Bill, as well as medical school. It is not restrictive.

DR. FAIR: But how about a private research institution like the Riverside Research institution that developed the tissue characterization for prostate?

DR. BERNIER: We can add that to it.

DR. FAIR: Okay.

DR. WARREN: So, George, are you saying, with 43, you want to take out "conventional institutions" and say, "and other research institutions"?

DR. BERNIER: No, that appropriate support should be made available through competitive award processes or CAM faculty, because that is the object of the research, curricula, and program development at accredited CAM, conventional, and other research institutions.

DR. GORDON: I think that is kind of redundant, a conventional institution is a research institution. We are not just talking about research. This is really the Education section. I just think that we are going to muddy the recommendation.

DR. FAIR: I will write something up, but the

idea is to get new brains and new approaches into looking at the problems of studying CAM.

DR. GORDON: Let's see if we can bring that into one of the other recommendations, Bill, where it may flow more naturally.

DR. PIZZORNO: Bill, this is Education and Training, and I think your comments are very appropriate, but I think they belong under the Research section.

DR. BERNIER: Thanks, Bill.

Joe.

DR. PIZZORNO: The second one, or No. 44, depending upon which list you are looking at, "The Commission recommends that joint research, education, and training programs involving CAM and conventional institutions should be supported to focus research on clinically relevant topics, improve the quality of research conducted, and link research with evidence-based education and training."

So, in the interest of speeding things along, is there anybody who can't live with that wording as is?

[No response.]

DR. PIZZORNO: Thank you. Nailed. Next one.

DR. BERNIER: "The Commission recommends that conferences should be convened by the proposed federal CAM coordinating office to assemble the leadership of professions, educational institutions, and appropriate organizations to determine the feasibility of, and possible mechanisms for, establishing national CAM education and training standards."

Does anyone have any problem with that? Charlotte.

SISTER KERR: I am actually reviewing the content before that, because I think this may just be again into the flavor. On page 7, for example, I just wondered if the tone in here didn't quite give the acknowledgment to those professions that have already taken initiative and continuing education.

DR. BERNIER: Charlotte, would you mind if we just stuck with the recommendation now, and then when we come back, we can go over other --

SISTER KERR: The only reason I was going to that is because it builds up to, for example, I will speak to the recommendation, but it is the same flavor. For example, "The Commission recommends conferences be

convened by the proposed" da-da-da "to assemble the leadership of professions, educational institutions, and appropriate organizations," and you could possibly say something like "to determine and to assist the various professions of the feasibility of possible mechanisms for establishing," do you understand? It is a sense of I wonder if it is acknowledging enough.

MR. CHAPPELL: I think that is covered under the description of the federal office itself as one of its functions, generally speaking. I think, Charlotte, that might be covered there.

SISTER KERR: Okay. It is just the sense of the tone, because when I went back to the content, for example, it says, "It is likely that continuing education requirements may evolve for CAM practitioners." Well, it has evolved, so it is a question of is the data accurate, and this is not my subcommittee, so, you know, "new disciplines, specific continuing education could be created, a more cost effective approach would be to develop and combine, you know, you go on to say.

I am just editing. It may be that it is a good idea to combine conventional and all in one conference,

but maybe not, so not to sort of say -- you know, we are saying this is what it should be. I think it is just the language, so we respect those who have evolved in their profession is the consideration.

Thank you.

DR. PIZZORNO: Charlotte, I think actually we have agreement there, because I had a couple of wording changes I would like to recommend, I think address what you are concerned about.

So, looking at 45, the first recommendation we make is on the second line, just before "Professions," and it says, "Assemble leadership of professions," I would insert in there, "CAM, conventional medicine, public health, and emerging health professions." So, four distinct groups: CAM, conventional, public health, and emerging. We are still on No. 45.

The second line, insert those four groups.

DR. WARREN: Repeat that.

DR. PIZZORNO: CAM, conventional medicine, public health, and emerging health professions. How about conventional health rather than conventional medicine, so we include more within that sphere.

I would add another sentence at the end of the recommendation, "National standards for CAM education and training already established in CAM professions should be identified and used as the basis for consideration."

DR. GORDON: National standards should be --

DR. PIZZORNO: There is already national standards -- I didn't say it as well as I should have -- there is already national standards for many of the CAM professions. That should be the starting point for this conference. We should recognize a lot of this work already exists.

DR. GORDON: The wording is what, "should be identified"?

DR. PIZZORNO: National standards for CAM education and training already established should be identified --

DR. FINS: Should form the basis for future development.

DR. PIZZORNO: Yes, good, "should form the basis for future development."

DR. GORDON: I would take exception to the last part of that sentence. When we say "form the basis," it

gives them an authority that I don't think they should have coming into this -- this kind of conference is to decide how much authority they should have, and decide whether they should have authority, and that is present there in the feasibility.

I think, you know, we are saying, on the one hand, we have an open mind, on the other hand, this is the way we are going to do it, and I think it is really important that we stay open to whether or not there should be national standards, so it is an open question.

We have heard a lot of testimony from people who are very concerned about that, both from the state level and from traditional healers and from sort of the popular healers, so I think that we need to keep open, and if we do, that last sentence closes the circle prematurely in my opinion.

DR. PIZZORNO: Okay, but we can't ignore what already exists.

DR. GORDON: No, I am not suggesting. I am just saying once you say they should be the basis for it, take that out.

DR. PIZZORNO: So, maybe a different

phraseology.

DR. GORDON: Or just leave it the way it is.

DR. PIZZORNO: Should be identified.

DR. GORDON: They should be identified and considered.

SISTER KERR: Just a clarification. Isn't like the Minnesota law -- which I can't remember where we put that in -- I mean, Jim's point, I think is important. I don't know, I lost it here, because we are talking about educational requirements, I am trying to make sure we create, being from the South, state rights, and no big brother here, and potential for evolution is I guess what I am holding for what may be with also protecting patients' rights, et cetera, and safety.

That is my point. That is what I was trying to get in there. Tom just said to me, well, I want to have a conference that creates a potential for dialogue, and I think that maybe is it.

DR. BERNIER: Would you like us to work on that?

SISTER KERR: Yes, please. Thank you.

DR. GORDON: What I would like, again, is if we

could make a decision here, and only in extremis, send it back to your committee. Okay?

DR. BERNIER: Okay. Joe.

DR. FINS: First of all, I think conferences is too micromanaging. I would say establish mechanisms that -- to assemble leadership blah-blah-blah. I think the word "standards" is a bad word, because I think it is the prerogative of each state and state medical board, and other licensing entities in the state to do this.

So, I think, you know, it is really to develop a consensus on educational and professional training, that the states can use to formulate their own individual policies. You know, basically, if this commission -- or this entity rather -- comes up with a consensus, and there is wide agreement, the states would evolve to accept that, but I don't think we can dictate it from the federal government.

DR. KACZMARCZYK: That is exactly why conferences would be a good idea.

DR. FINS: But I think conferences sound a little too nitty-gritty, but a mechanism, including conferences --

DR. PIZZORNO: Tom.

MR. CHAPPELL: Is the intent to establish national standards or to facilitate national standards, or to facilitate standards at state level? I am thinking about words like dialogue and facilitate as part of the solution here.

DR. PIZZORNO: Maybe a better term, rather than standards, would be guidelines, because the intent is not to be prescriptive to states, but rather to provide them something they can use in making their own decisions.

DR. FINS: Consensus is a good word because that implies a dialogue, and it is not a done deal when you get there.

MR. CHAPPELL: I don't know. I think "facilitate the dialogue" allows people to learn from one another, but to go back to their respective places and fix whatever they want to fix, but it is not arriving at a national consensus or a national standard, unless I am missing the point.

DR. BERNIER: No, it is not.

MR. CHAPPELL: It is not. Then, this sounds like we are trying to establish a national standard. We

are using words like "determine a national standard," and I think that is what is wrong with this. So, I think we need to use words like "facilitate the dialogue."

DR. BERNIER: Foster?

SISTER KERR: It's the outcome that is the problem.

DR. WARREN: Do we consider this a recommendation from the entire group, or do we just consider this a guiding principle or a guiding light for CAM Central? Is it just some way to facilitate the action of CAM Central?

DR. BERNIER: Do we have an answer over here?

DR. LOW DOG: I don't have an answer, but I have part of the question. When we have in this recommendation about the Federal CAM Coordinating Office, I mean, what if there isn't one, should we be putting that into these recommendations, because that is a recommendation, is to have the office?

And if we are recommending it, should it go under the section under what that office would do to build it up, to build up that section, so that it looks like it has more teeth?

DR. WARREN: Well, that was the one thing we got a consensus agreement on the last time, that was the one thing that we unanimously said, we needed a CAM Central Office. I see this as one of the guiding things for CAM Central.

DR. LOW DOG: My question comes to, does it go here, because what if there isn't one? We unanimously agreed, but what if other people don't and there isn't one, then, what happens to this recommendation, because you have said this is what it is going to be, this is who is going to do it, well, what if that doesn't happen?

I am not sure that it should be in this part of the text, and if we think it is something the office should do, then, shouldn't that be then moved into the section on the CAM Coordinating Office, so that you give them more strength, so it looks like this is just one more thing it could do, and shouldn't this be more generic in who is going to do it?

It is just a question, I don't know, but it just seems like if you are building a lot of stuff on an office that may or may not exist, then, what will happen to this recommendation if it doesn't come into being?

DR. GORDON: Steve will answer the point that Tieraona is raising.

DR. GROFT: We are looking at a recommendation that we have, that we have already agreed upon as far as establishing a central focus, a coordinating focus. We will not, in all likelihood, get it this year, Fiscal Year 02. What happens next year in Fiscal Year 03 is something else.

Whether we get language or direction from the Administration or from Congress to prepare a plan, an implementation plan to look at the recommendations from the Commission and then submit it to the Congress, to the Administration, we don't know.

Those types of requests are frequently made. We are not finished yet, or I should say Congress is not yet finished with the appropriations language for Labor, Education, HHS. Whether we ever get to this stage or not, we don't know.

So, not to avoid the question, but if there is no office, others can pick it up within the government and foster this activity. For example, the National Center for Complementary and Alternative Medicine could

do this along with the Office of Cancer Complementary and Alternative Medicine, Jeff White's group.

So, there are groups that can pick this up. HRSA could pick it up under --

DR. GORDON: Steve, is there a disadvantage to putting the office in, or is there an advantage to putting the office in?

DR. GROFT: I think you want to keep the office, we want to make it firm, and perhaps at lunch today I can talk about some other things. You know, someone had mentioned maybe this shouldn't be a recommendation, Donald said maybe it shouldn't be a recommendation, it should be something else, and perhaps I can address this a little bit more at lunchtime.

MR. CHAPPELL: I have some edits for this.

DR. LOW DOG: Could I just have the follow-up then? Is this recommendation then also cross-referenced under the section on the CAM Federal Office?

DR. GROFT: Yes, it is.

MR. CHAPPELL: I have some edits to this 45. The language would remain the same -- educational institutions and appropriate organizations to help

facilitate dialogue which helps clarify CAM education and training standards to be appropriated to respective states and professional organizations.

DR. LOW DOG: That sounded good. Could you read it again?

DR. GORDON: Let me make a procedural point. We have about four or five different suggestions for changes in wording, and I am wondering, George and Joe, if you want to synthesize these on the spot and give us the wording that is up right now.

DR. BERNIER: Tom, if you will stay with us on this. The Commission recommends that conferences should be convened by the proposed Federal CAM Coordinating Office to assemble the leadership of professions, educational institutions, and appropriate organizations to help --

MR. CHAPPELL: -- facilitate dialogue, clarifying CAM education and training standards.

DR. GORDON: Okay.

MR. CHAPPELL: I haven't finished -- to be appropriated to respective states and professional organizations.

DR. GORDON: Okay, and there are other changes that you suggested.

DR. BERNIER: Why don't we just hold here for a second. Would we all endorse that?

MR. CHAPPELL: I am trying to use the office as a convener and discussion place, and not as a body that dictates.

DR. GORDON: George, the reason I am raising the question is I am confused because Joe Pizzorno added some other language, as well, Charlotte added some language, and we need something that somehow takes account of all the different additions. At this point, I feel like we need some synthesis because otherwise we are going to keep going back over it and over it again.

So, I am asking you two to get up with something that synthesizes the different points of view that have been presented.

DR. BERNIER: So, we have general consensus for approval with the additions to go on? Okay, we will do that. They are brief, but I think we will have to go digging through it all.

DR. GORDON: No, we really would like you to do

it -- Joe K. is shaking his head, and I agree -- we really need to do it on the spot.

DR. PIZZORNO: As kind of the structural foundation of this, is everybody okay with the modification that Tom made? We are going to modify it a little further, but that just changed that first sentence significantly. Are we okay there?

DR. FINS: I think we should just take out "conferences," and say "mechanisms," you know, which might include conferences. You don't want to limit it.

DR. PIZZORNO: Any problem with that, substituting "mechanisms" for "conferences"?

MR. CHAPPELL: No, I am not comfortable with that change.

SISTER KERR: I am not sure what "mechanisms" means.

DR. BERNIER: How about "colloquia"?

MR. CHAPPELL: I am not sure anyone would come.

DR. GORDON: My concern is that, if at all possible, we don't want to be referring things back to your subcommittee, and so either we go through the rest of the recommendations and then we come back to this one

and work on it here -- we may run into this kind of wording issue with every recommendation or with many of the recommendations, and we just cannot refer everything back to the committees.

DR. KACZMARCZYK: Mr. Chairman, since we are so close to closure on this, may I suggest respectfully that we complete the task at hand?

DR. GORDON: I would be very pleased.

DR. FINS: I don't like appropriated, I like the concept that we reach a kind of consensus through this process, and then share these thoughts with the states, in other words, I agree that it is a state responsibility, but I don't like the "appropriated" language, I think it is confusing.

SISTER KERR: To me, this recommendation did not have the appropriate spirit of what now we are trying to convene, which was to assist the professions to do their job. Whether it would be to say we don't believe in continuing education or 36 states say we do, but we have got to allow people to do their own evolution, and we are just offering to bring them together.

This is a highly individualized, autonomous

group of people, and we start saying you all come together now, so we can tell you what we think you ought to do, so we can all get health care reimbursement. This is not going to work.

DR. GORDON: Can you, either Joe or George, put together all this and read something back to us now, that you feel fulfills the spirit?

DR. PIZZORNO: Okay. The Commission recommends that conferences should be convened by the proposed Federal CAM Coordinating Office to assemble the leadership of CAM, conventional health, public health, and emerging health professions, educational institutions, and appropriate organizations to help facilitate dialogue, clarifying CAM education and training standards -- instead of standards -- guidelines.

DR. GORDON: Are we okay with this? And then what was the last part?

DR. PIZZORNO: Oh, "guidelines," and then "appropriated to the state and" --

DR. GORDON: "Appropriated to" doesn't make any sense.

DR. PIZZORNO: I don't like "appropriated"

either.

DR. GORDON: Which will be shared with the states.

DR. PIZZORNO: Made available to the states and the professions.

MR. CHAPPELL: For consideration.

DR. GORDON: Do we agree with this one? Sold. Okay. Let's go on. Good work.

DR. PIZZORNO: Number 46. The Commission recommends that all CAM and conventional education and training programs should develop curricula and other methods to facilitate communication and foster collaboration between CAM and conventional students, practitioners, researchers, educators, institutions, and organizations.

Joe.

DR. FINS: I completely endorse the idea, but i would like all the "shoulds" to be "should consider," because the quickest way to upset an academic institution is to have it seem like a mandate. You will get a lot further with that, believe me.

DR. PIZZORNO: Should we remove "should" and

say just "develop," or is that still too prescriptive?

DR. FINS: It is too prescriptive.

DR. PIZZORNO: Okay, "should consider developing."

DR. FINS: Just "consider developing curricula."

DR. PIZZORNO: How does the Commission feel about that?

DR. GORDON: Why not take out the "should" and just have "develop."

DR. FINS: It remains prescriptive.

DR. GORDON: I understand.

DR. FINS: But you don't because, you know --

DR. PIZZORNO: I am going to cut you off here for a second. We have got three proposals, one, leave should, remove should, and the other should consider. Let's hear from some others, what is the Commission's preference here? Tieraona.

DR. LOW DOG: I would put down also, for CAM schools, I mean, you are saying that they must develop this curricula to facilitate -- I mean, I am not sure that it should be on either side. I think that "should

consider," I think is important to allow freedom of all people, not just conventional and academic centers, but also different CAM schools, and depending upon --

DR. PIZZORNO: Well, this applies --

DR. LOW DOG: Yes, but "should consider," I would vote for that.

DR. PIZZORNO: This applies equally to both conventional and CAM.

Wayne.

DR. JONAS: I disagree that we should soften it by saying they should consider. They are already considering it, many of them are considering it, therefore, it is done. I think we should be clear that we recommend that it should be done, and, you know, they can decide whether they are going to do it or not. Anyway, that is my opinion.

DR. PIZZORNO: Thanks, Wayne.

Other Commissioners would like to comment on this? Conchita.

DR. PAZ: I agree with not softening the approach. I think we need to make a pretty strong statement on that.

DR. PIZZORNO: Thank you.

Julia.

MS. SCOTT: I agree that we need to step up here and say that they should.

DR. PIZZORNO: Ming.

DR. TIAN: I agree, too. I think we make stronger.

DR. PIZZORNO: I think unless I hear otherwise, I think I just saw consensus develop for strong language.

DR. FINS: I will tell you I think you are winning a rhetorical argument, but you are going to lose the war, the curricular wars. We have been through this with the palliative care question, what is palliative care curriculum, and by trying to work and collaborate at least on the conventional side, you are going to get a lot further than academic -- this will read like an academic mandate, and that will be highly counterproductive.

I think it's a rhetorical modification that has tremendous significance, and it could be taken the wrong way as a mandate. So, I would like this to be implemented. Maybe we say "should consider" -- to

capture Dean's point -- "should consider the development and implementation of," so it doesn't just get left dangling as "should consider," and this way we could compromise.

DR. BERNIER: Actually, what we could do is to just take out the "should."

DR. FINS: It is still prescriptive.

MR. CHAPPELL: I go along with dropping the "should."

DR. KACZMARCZYK: How about somewhat of a compromise, saying "should give serious consideration to development and implementation," because that tends to capture a lot of what has been said so far.

SISTER KERR: My comment was just that even with the "should" out, it is a declarative statement, and it's definite.

DR. PIZZORNO: We have a challenge here. Clearly, we all agree that they should do this. So, the question here is should we be clear about our decision or should we modify it in such a manner that we think it might be better accepted.

I, by the way, think this should be mandated

for all conventional CAM institutions to learn how to talk to each other. I mean, it doesn't make sense what is going on otherwise.

I want to again see if we can come up with some resolution here. We had some language recommended by Joe K. that might be considered an acceptable compromise.

How does the Commission feel about that? Read it again, Joe.

DR. KACZMARCZYK: Basically, it is the same recommendation, but instead of saying "should," it would be "should give serious consideration to development and implementation of" -- blah, blah, blah.

DR. PIZZORNO: Wayne, can you live with that?

DR. JONAS: I heard "should" in it even though you said take "should" out of it. So, could you rephrase it again?

DR. PIZZORNO: "Should seriously consider development and implementation."

DR. JONAS: Oh, I see, we have added in "seriously" to show that we feel strongly about it. That's fine.

DR. BERNIER: Actually, there is a slight

difference. When we say the Commission recommends that the programs develop curricula, we are sort of halfway between requiring it --

DR. JONAS: Yes, that is what I thought you said. That is fine with me. I mean, I have no problem with that, but I don't think that is what Joe wanted.

DR. KACZMARCZYK: Let me try and make an on-the-spot edit here. The recommendation may read as follows: "The Commission recommends that all CAM and conventional education and training programs should give serious consideration to development and implementation of curricula and other methods to facilitate communication and foster collaboration between CAM and conventional students, practitioners, researchers, educators, institutions, and organizations."

That tries to capture everything that has occurred in the dialogue to this point.

DR. FINS: The operative word for me is "consideration," so that is fine, I can live with that.

DR. BERNIER: Effie.

DR. CHOW: Sorry, I don't like the word "consideration," because you can consider for a lifetime,

and not really develop things. I go along with dropping the "should" and say, "conventional education and training, develop curriculum and other methods."

DR. WARREN: If you tell me I have got to do it, I am going to tell you where to kiss it. I think you should them, all the professions and all the organizations the latitude to say I can do it if I want to.

DR. PAZ: We are recommending already, Don, you know. When you make a recommendation, that is recommending it, and you just leave the "should" out, because you are recommending it. I mean, we are making that stand.

DR. PIZZORNO: The facilitators have consensus, we are dropping "should." Onward. We are dropping "should," everything else as is. "The Commission recommends," we are not prescribing, we are recommending, and we are removing "should," so it still is declarative, but not as strongly declarative, removing the "should."

So, reading for hopefully the last time, unless somebody becomes totally unglued: "The Commission recommends that all CAM and conventional education and

training programs develop curricula and other methods to facilitate communication and foster collaboration between CAM and conventional" -- et cetera.

How does that sound? Okay. I am seeing primary nodding of heads. We will move on. Thank you all.

DR. FINS: I reserve the right to disagree.

DR. GORDON: Okay. You can't live with this one then is what you are saying.

DR. FINS: You know, I liked what Joe had. It's stronger. I will just maybe have to maybe disagree.

DR. GORDON: Okay.

DR. FINS: You know, it is really unfortunate. I mean, working in a medical school -- just indulge me for a moment, because I really think that you are going to get further.

I mean, the medical school faculty around this table understand how this works, and I think Don's point, you know, of coming in and telling people what they must do in the context of an academic environment is offensive to academicians, and if you want to make inroads in the allopathic medical school community, and with the

organizations of organized medicine, you should, I think, try to make this palatable to them, and not make it a mandate. You want to foster the collaboration, it is already there.

You can win the rhetorical battle, but you are not going to endear yourself to curricula committees.

DR. BERNIER: I would differ with you on that. It seems to me the way it is stated, it's we are recommending a curriculum, that the faculty develop a curriculum.

DR. GORDON: We need to move on.

DR. BERNIER: It is only a recommendation.

Recommendation No. 5 or 47. "The Commission recommends that core elements of a biomedical science and conventional health care curriculum for CAM education and training programs should be determined along with methods for incorporating into existing curricula through demonstration projects and conferences with subsequent results, models and recommendations compiled and available on the Internet."

Any thoughts on that?

DR. GORDON: The question I have is why are we

putting the Internet in here, when we don't do it in the other places?

DR. PIZZORNO: I think we should just drop out "available on the Internet." I agree with you.

DR. GORDON: Fine.

SISTER KERR: You know what, I just don't understand this No. 5, like if I was just reading it or giving a lecture, tell me what this means. The "core elements of a biomedical science and conventional health care curriculum for CAM education and training programs should be determined," is it saying that we should identify biomedical science content and conventional health care for CAM education should be determined along with methods for incorporating -- it's just like a little bit of a muddle. I just don't even quite understand what it is asking.

Is this a comment on suggesting what kind of conventional medicine information should be included in the CAM curriculum?

DR. BERNIER: Yes, it is.

Joe.

DR. FINS: I think we are going back to the

February meeting, the idea was what does the CAM practitioner need to know from the allopathic side to competently care for their patients, know when to transfer, to recognize signs, and things of disease, and that was it.

It was a core curriculum, it wasn't turning them into allopathic practitioners, but just core skills, and then there was a corollary what we would need to know on the CAM side.

SISTER KERR: I absolutely agree with that, I mean, like in our school, it's a major thing. It is just that the wording is not clear to me that is what it is saying. I am absolutely in agreement.

MS. SCOTT: I also think the wording could perhaps change to something like, "The Commission recommends that CAM education and training programs include the core elements of a biomedical" -- that way, you are putting the subject that you are talking about, and then what you want them to do. I think it reads a little better.

DR. FINS: And then add the appendix necessary for appropriate patient care, which makes it commensurate

with the level of activity.

DR. GORDON: I would agree. I think that Julia and Joe are on the way to simplifying it. I think we are also putting a different thing because we are saying on the whole determined business, which we don't do in most other places. Simply making some statement like this will be clearer.

DR. FINS: Right.

DR. WARREN: When I read all these recommendations side by side, it seems that this recommendation should come under the umbrella of the last recommendation of this group.

For some reason, the logic of it, the last recommendation was demonstration projects.

DR. FINS: Do you mean No. 51?

DR. WARREN: Yes, No. 51 on the big sheet, and No. 9 on the little sheet. It's the last page in that section. It seems like you are doing a training program, you are doing some type of demonstration project to gather all this information to see if it is going to work or not.

DR. GORDON: To me, I think this is different.

I think this is symmetrical with the recommendation that conventional practitioners know about CAM. This is the other side of that, and it is different from the collaboration, different from No. 51, which is kind of postgraduate training program.

DR. KACZMARCZYK: I have a concern about deleting the "to determine," because if you do that, that presupposes what should the core elements be and how do you suggest that those core curricula elements be identified.

DR. GORDON: You could say that the same issue exists regarding CAM, you know, what should be included of CAM, and that we don't say "to be determined."

DR. FINS: Can we just maybe use parallel structure, take Recommendation 4, which I was dissenting on, but since I will be editorially helpful here, why don't we just use the same exact language and reverse it, and have parallel structure?

DR. GORDON: What would that sound like, Joe?

DR. FINS: You have got me. In the spirit of collaboration, right?

DR. GORDON: Yes, of course.

DR. FINS: It would be, "The Commission recommends that all CAM education and training programs develop curricula that captures the basic elements of conventional medical practice in order to ensure safe and effective care of patients who use their modalities," or something like that.

DR. GORDON: I would say, "reflects the fundamental elements of biomedical science and conventional practice," and then continue the same way.

DR. FINS: Right.

DR. JONAS: And along those lines, perhaps we should also use "developed" rather than "determined." Did you use that, Joe?

DR. FINS: Should develop, right.

DR. JONAS: "Develop," no "should."

DR. FINS: Right.

DR. GORDON: "Develop," yes, no "should."

DR. FINS: I am already on the record on where I stand on the last one. I think we should strongly consider it.

DR. BERNIER: Could you repeat the whole thing?

DR. FINS: "The Commission recommends that all

CAM" -- there is a transcript, so we will just get it off the transcript. How is that?

DR. GORDON: With my emendation to what you said?

DR. FINS: Yes, biomedical.

DR. GORDON: Okay. Great.

DR. PIZZORNO: Number 6 or No. 48, depending on which list you are looking at. "The Commission recommends that traditional healers should be educated and trained in accordance with their respective established traditions to ensure that culturally appropriate access to traditional healers and healing is maintained."

DR. LOW DOG: I would just get rid of this section. I have some real issues with education of traditional healing education and training.

DR. PIZZORNO: What is your concern?

DR. LOW DOG: Well, I think that, for one thing, you can't really adequately define traditional healers and traditional medical practitioners, and that you are on a very slippery slope here, you know, where you have traditional Yugoslavian practitioners

traditional Puerto Rican healers, traditional English healers, I mean, how far back in what tradition.

I think that when you read the recommendation, "be educated and trained with respective established traditions," they are varied. They are very varied, and they are all over the place, and so I am not sure what the purpose of the intent of this recommendation is. I am not sure what you are intending to happen with it, because it exists as it already does, and you are not going to capture it.

I would leave it out is my own feeling.

DR. GORDON: Do you want to respond with why you thought it was important to have it in, so that we can then discuss it further?

DR. BERNIER: It is very clear this is an issue that has popped up in every facet of this program in that the idea of whether licensure is needed or not needed, whether or not an individual could function as a healer on the reservation and then move to New York City and continue to practice.

There has been a lot of discussion about this in a great many of the subcommittees, and I guess we felt

we had to say something, but it is really hard to do that. One logical thing would just be to drop it, because we aren't going to work out how or what kind of support that people are going to find who are native healers.

I guess what I am trying to say is that there is no clear answer, and I hoped someone would correct me if I am wrong on it. There did not appear to be any clear answer, and this was one way out of it.

Joe?

DR. FINS: We should probably wait and get Buford's input on this particular issue, because he would obviously have a point of view pro or con, and I think we could just shelve it for now, come back to it, and hear from Buford on this issue.

DR. CHOW: I don't think the American Indians are the only ones pertaining to this issue. There are many cultures. I strongly believe that something of this nature should be included because it protects them from being forced into Western medical licensing or Westerns standards of licensing, and this is saying in accordance with their respective established traditions, so it is

like accepting their tradition as a long traditional training instead of forcing them into a modern Western standard of licensing.

DR. KACZMARCZYK: In Buford's absence, I would like to recount some of the themes that have come up in dialogue with him. His concern is protecting the integrity of these rich traditions, and that is protecting them from the exploitation under the rubric of CAM, so in my opinion, that is the overriding reason for having anything in the report about traditional healing.

DR. LOW DOG: Which is part of my point. Right now, like in New Mexico, there is already state laws about the practice of traditional medicine and traditional healers. We have it on the state law because it is so big in our state, so there is protection.

If you use the argument that traditional medicine practitioners, that it shouldn't have to be forced, they shouldn't have licensure, then, you could use the same argument for traditional Chinese medicine, say there should be no licensure, nobody should have to go through school or training because you are practicing traditional Chinese medicine.

You could use the argument because at some point, all of us have a tradition, and you could just say you have gone back to it. I am not sure how that promotes the integrity or protects the integrity of true traditional practitioners when you are going to get a lot of abuse out of this type of statement.

I think that, one, under Access or Licensure, or things like that, it is more appropriate to discuss about the protection and integrity of those practitioners under those sections than under Education, which I am not sure what the purpose of the education is in here. I think it is better placed under different areas of our document.

DR. PIZZORNO: Conchita.

DR. PAZ: Well, I think that the Native Americans are certainly more organized than a lot of the other ethnic groups that have their traditional healing. I know like with some of the different hispanic communities, there is nothing very formal as far as their education, and, frankly, a lot of them are not even trained here in the United States, they are trained elsewhere.

A lot of that is very under -- what is it -- undercover, I mean, people are like by word of mouth, there is nothing that you can find out about that, and it is only by particular people that are doing that or know someone who does it.

So, it is very difficult to even know who is healing sometimes, much less know where their education is coming from. However, I think by having some of the Native American as a sort of model, because they are probably more organized than some of the other ethnic groups as far as their education from what they have tried to do in the past, that could certainly serve as a type of model that we might be able to use in the future.

DR. PIZZORNO: Thanks, Conchita.

Ming.

DR. TIAN: I agree with Conchita, and I think it is important that we respect each other. Whenever we understand this, can be licensed, and if it's not ready, it's not licensed. For instance, qigong masters, we don't have enough knowledge to identify or evaluate whatever they did, because we don't have enough scientific data or evidence to show, but it doesn't mean

they are not healers.

So, in all documentation, we should have that sense, we respect each other, and especially for those healers, traditional healers, we should not give say if you are not licensed, you cannot practice. That could be abuse because the point is not -- they don't have problem, we have problem because we don't have enough scientific information, and as commissioners, we don't have that position to evaluate each treatment or therapy.

DR. GORDON: I would like us to get consensus on this now, because we have a couple of other very significant issues coming up.

DR. PIZZORNO: Joe, do you want to make a last comment on the recommendation?

DR. FINS: It may be something that could be thought of as a principle, you know, that we respect various healing traditions and the pluralism of healing that exists in this country from different traditions, and not make it so much a recommendation, but somehow bring it into the Principle section, because I think that is what Ming was saying, it's a matter of respecting difference, not necessarily licensing it, but respecting

it, and the in the operationalization, I think Tieraona's point is probably right, it can be dealt with in the Access and Delivery section where we are talking about licensure.

DR. GORDON: We already have it as a principle in a sense, because that was a phrase that we inserted with respect for the integrity of those traditions.

Do we need it here under Education, do we need a recommendation?

DR. PIZZORNO: We have three possibilities here. One is simply leave as is, which I don't feel much consensus for. The second is to wait until Buford is here to get his input on this. The third is to move it over to Access and Delivery, because it sounds like a lot of the conversation hinged more around access and delivery rather than around education.

Can I get any kind of consensus from the group here what to do?

[No response.]

DR. PIZZORNO: How about we move it to Access and Delivery?

DR. GORDON: Will you accept that, the Access

and Delivery? No?

DR. PIZZORNO: Do you want to say why, Linnea or Joe?

MS. LARSON: I think we had four areas that we could do, is we accept as it is; two, we accept with modification; three, we send it back to the workgroup; and, four, we delete it. So, those are the terms.

If we are going to have a coherent structure or process, this goes back to the workgroup or we delete it or we change it now, or we agree on it.

DR. LOW DOG: I think that it is a naive perspective to think that traditional medicines, that you even have an established, a respective, established tradition. Part of the nature of many of these traditions is that they are very eclectic and they depend upon what region you come from, they depend upon your own personal journey and experience. That is the nature of many of these traditional healers.

I just think it's trying to take this very separate kind of entity and squeeze it in a box, so it looks nice, about education, and I just think it misses the boat entirely.

DR. PIZZORNO: So, if we were to drop it, drop it from this section, would the Commissioners feel acceptable with that? Is there anybody who objects for us just simply dropping it?

DR. PAZ: I think we need to have some way of trying to address it, and I think we need to keep this. It doesn't apply to all our culture groups, but I think it is a way to get started as far as legitimizing these other therapies, but it is just a drop in a bucket.

DR. PIZZORNO: Effie, and then Julia.

MS. SCOTT: No, no, I think we should delete it, but I wanted to give my rationale for doing that.

DR. PIZZORNO: I saw your hand before I saw Effie, so let's hear your rationale.

MS. SCOTT: I will do it. I vote also to delete it. I am very troubled by this, you know, trying to educate and go in with traditional healers. I think what I read through the text, there is a concern that these traditions be kept and be, you know, brought down, so they are not lost.

I don't think this recommendation addresses that, however, in the next section, Access and Delivery

of CAM, there is a recommendation, Recommendation No. 63, that I think states more the Commissioners' views on this, so for those reasons, I think we should delete it from this section. I don't think it is appropriate here.

DR. GORDON: Thank you, Julia.

Does everybody want to look at No. 63, check that out.

DR. PIZZORNO: Effie, is there anything you need to say here?

DR. CHOW: Yes. I strongly recommend to keep it in this section because it does deal with training and education, and the special consideration of the depth of culture, and I think that can be easily forgotten, and I think it has been illustrated in one aspect of taking acupuncture and moving it, isolating it into a modern Western medical program, and it is not as effective as it has been.

DR. PIZZORNO: Effie, thank you for that strong position. We need a resolution.

DR. CHOW: I would like to keep it.

DR. PIZZORNO: I think we have a consensus that you want to support and respect the traditions. I am

also hearing a consensus that there is no formal educational program that we can endorse and recommend. So, it may be that we are trying to respect a tradition, but saying something about it in the educational program is not the place to do it.

DR. CHOW: But I am look at it from a preventive standpoint, because we are making recommendations for the future, not just now.

DR. FINS: The imposition of educational expectation on a healing tradition would be more -- not only would it not be respectful, it could be constricting, and I think, you know, Recommendation 63, that Julia brought to our attention, perhaps could be modified just slightly.

Here, it is sort of like the practice of these things. Maybe we could do a review of the education and report back, and put that in the Education section. But I think it is captured nicely in 63, and I am wary about imposing an expectation on what could be construed as a religion, it is a Bill of Rights issue.

DR. PIZZORNO: Tom, last comment on this, and we are going to make a recommendation.

MR. CHAPPELL: I think what we could do here is to recommend the affirmation of all healing traditions. We need a statement here that affirms traditional healing methods, and just makes that statement as one of affirmation and leaves it there.

DR. PIZZORNO: But does that belong in education?

MR. CHAPPELL: Well, because I am hearing the point about inclusivity, yes.

DR. PIZZORNO: George and I have a request, and that is, we seem to have a very clear differentiation, leave it in as is or some modified form, or remove it and assume enough can be found in 63 to make it work.

So, we would like to simply see a show of hands, so we can decide whether we should try to continue work on this or stop at this point.

Those who think we should leave it in as is or with slight modification, please raise your hand.

[Show of hands.]

DR. PIZZORNO: I count four.

How many believe we should remove it from this section and just have adequate wording done in No. 63 to

handle it, please raise your hand.

[Show of hands.]

DR. PIZZORNO: Ten.

DR. GORDON: I would like a directive.

DR. PIZZORNO: The vast -- this is not exactly consensus, but the vast majority said delete it and move the relevant language over to Access.

Can anybody not live with that? If you can't live with that, then, we will go back to committee. Okay. We are moving it into 63.

DR. GORDON: With direction, Joe, to pick up on what you were suggesting, that you bring in some language to take account of the educational, if you can.

DR. PIZZORNO: So, we have a consensus to move it over to 63 and leave it to Access to finish up.

Okay. Gone. Thank you.

DR. BERNIER: We have 19 seconds.

DR. GORDON: Actually, we have cut lunch down to three sprigs of parsley.

[Laughter.]

DR. GORDON: What I want to do is we will give 15 more minutes for these next two, 5 for mine, 5 to

conclude, and then we will have some time for lunch. The consensus is pretty clear, so I am not going to need to make a lot of comments on that.

DR. BERNIER: We also are a half-hour late.

The next one is No. 7, if you have that version. "The Commission recommends that demonstration projects should be developed to determine the feasibility of expanding the role of appropriately trained CAM practitioners becoming primary care providers, so that the eligibility of CAM students to participate in existing loan and scholarship programs and CAM practitioners to participate in loan forgiveness programs can be evaluated."

DR. GORDON: I have to say I find this a kind of garbled recommendation, because you are recommending demonstration programs, so that students can participate in loan and scholarship programs, it doesn't seem quite right to me.

The question is -- I mean, I understand what you are trying to do, but it's just a very strange way, it's like recommending a program, recommending an expansion, so that people can get included in something

rather than either recommending the expansion in Access and Delivery where it would be appropriate, or recommending loan forgiveness in this section. It is just sort of mixing apples and oranges to me.

DR. BERNIER: Well, I would have to say that there have been a number of people who have had some concern about it, and partly the way it is formatted and partly that the identifying one kind of physician or other health provider, that individuals who are coming through the CAM track would end up being eligible for scholarships, et cetera, and it makes it seem like it's not so much to educate them, but it is to give them some money.

DR. PIZZORNO: The point we want to make here is yes, the wording is awkward, because it was our best effort to kind of put together all the compromise language that we thought was agreed upon at the October meeting.

So, the idea was that to determine through demonstration projects if it was appropriate for CAM practitioners to function in rural loan forgiveness programs.