Joe, you want to say something, different language?

DR. FINS: First of all, I don't think based on the definition of what primary care providers are that these folks can be designated as primary care providers. It is very clear what they are.

What I thought we had agreed to in October was we would have demonstration projects to look for cost-benefit analysis or whether or not the pairing of a CAM practitioner, as well as an allopathic practitioner, led to improved cost-benefit, and that was where we left it, and if that number was positive, in other words, if that showed that one plus one was two and a half, then, we would consider some sort of mechanism to fund it, but there was a lot of controversy over whether or not it would go into the loan forgiveness program because it entangled it in the primary care definition.

So, there are other ways of funding these things, but at this point, it reads as if, you know, we are going to do this study because we know it is going to turn out a certain way, and then we are going to have loan forgiveness.

I think that, you know, obstetrician/gynecologists, pediatricians, internists, and family practitioners will have a difficulty saying that there is parity that these folks can provide primary care.

My understanding is many chiropractic practitioners are against vaccines. Vaccination is one of the mandates of the primary care practitioner under the Public Health Service Act.

I mean, I think we are getting three of four steps ahead, and I think, Joe, I think it would be helpful to see whether or not the collaborative models of care were productive, but not linking it to all these other entanglements and all these definitional issues, which will be -- you know, Dean is here -- this will definitely be a land mine.

DR. PIZZORNO: Joe, I think we need to improve the wording on this, too, and I also think there were two separate issues. One was how the situations work, CAM primary care providers can practice independently in rural areas where they are needed and conventional are not available, and the other one was can they practice

collaboratively together and, as you say, augment the results, and that we can't make a decision on either of those without demonstration projects.

I don't think we have the wording here well enough for that, and I hate to say this, but I think with the amount of time that is available, this has got to go back to committee, and we have got to do some more work on this one, because I don't think we got it quite right.

SISTER KERR: I just want to say I do agree with that. I really see the separate issues, and one that is glaring out is that somebody wants to say who can become a primary care, and that needs to be a whole separate issue.

The other one, I just want to add is your thinking. I don't necessarily personally agree should we be looking at primary care providers as kind of CAM or some other one to be eligible for loan forgiveness. I think we got into this last time.

For example, like I said before, chiropractor acupuncturists could be selected by the community as someone they want or there is evidence they are helping, and absolutely there should be a level playing field for

loan forgiveness in my opinion.

DR. BERNIER: Let me just ask if people would find, if we dropped off everything after the first two sentences --

DR. GORDON: Wait. It is only one sentence.

DR. BERNIER: I'm sorry. "The Commission recommends that demonstration projects should be developed to determine the feasibility of expanding the role of appropriately trained CAM practitioners," period.

DR. GORDON: I don't see that is an education issue. To me, that is an access issue. The education issue relates to the loan repayment or scholarships.

DR. PIZZORNO: This is all about loan repayment. That is what this is all about.

DR. GORDON: Yes. I think that is worth considering, but worth considering under Access and Delivery.

DR. KACZMARCZYK: I think it is well to remember that these programs are not educational programs, they are service programs to meet the needs of medically underserved populations.

DR. GORDON: So, the question I want to re-pose

to you two and to all of us is what is the educational component here and is there a recommendation that we want to make, and that we do that swiftly.

DR. FINS: I think there are two objectives behind this recommendation from those who are proponents of it. One, it confers tremendous legitimacy to these other practitioners to clump them together in a federal entitlement that says you, too, are a primary care provider, which I think is the first point, and the second point is that, you know, many of the students would like to be eligible for loan forgiveness.

Those are two separate issues. The first is highly problematic. The second, you know, may be feasible for some sort of loan forgiveness, but not in the context of a service program, because a lot of these things have not demonstrated that they are value-added or that they provide service.

So, the idea was to have a demonstration project to show that these folks actually improved wellness or the efficacy of the health care system to which they were placed into, and if that were the case, then, in the next go-around you would have an argument to

make that there should be some federal entitlement to foster this through loan forgiveness or payment.

DR. GORDON: Is that under Access and Delivery, or is that under Education, Joe?

DR. FINS: I think the loan forgiveness question would clearly be relevant in the Educational section, but the studying of whether or not this was a value-added thing could be in Research, under Health Services Research, or under Access and Delivery, as a delivery process.

DR. GORDON: Let me just pursue that. Is there a recommendation you have here under Education? That is what we are looking for right now.

DR. FINS: As currently stated right here, this is an Access and Delivery or Health Services Research question. The loan forgiveness part is the Educational component.

DR. BERNIER: Joe, what would you think about my suggestion about the first two lines of that document?

DR. WARREN: I think we need to delete the whole thing.

SISTER KERR: I disagree. I think the first

part is what should be deleted. The primary care thing is inappropriate here, and I not only think it is not educational, I think it is political, but I also think the second part of loan forgiveness is absolutely educational, and I am not sure we know what the criteria is for those who are eligible, and it would be a case of somebody giving input here of if you meet that, whatever you are called, then, you are eligible.

If it involves like, you know, you do this for a community or there is this evidence-based research, so if somebody can speak to that, we would know -- I think Wayne had a few comments on that.

DR. JONAS: I just want to say eligibility for loan repayment of current practitioners is not dependent upon whether they have demonstrated effectiveness in any particular thing, so those are two separate items.

Certainly, I think this should be sent back to rephrase it, so that it specifically an educational issue around loan repayment, take the demonstration out and put it somewhere else.

DR. GORDON: Can you give us some wording, Wayne?

DR. JONAS: Yes, in a minute.

DR. PIZZORNO: I need to make a comment. First, Joe, I really object to your phraseology and imputation of motives, although I do appreciate the political position advice, it just actually makes a lot of sense.

This is here for two reasons. Number one is because communities are asking for CAM providers in their underserved and underprivileged populations, and they need this, and they perceive that need.

Second, we have students who want to go and practice in rural underserved areas, who don't mind the decreased income and the lack of some of the advantages of living in the city.

So, right now we have this happening, and Washington State, unfortunately, is the only stuff I know of, where the communities are demanding it, and they can't get them because the federal language does not allow it.

So, the understanding I thought we had was let's do some demonstration projects of allowing this to happen, and let's see what happens, let's see is it a

benefit to the community.

I think we can work on the language to make that work better.

DR. FINS: But if you look at lines like 414 to 422, I thought the conceptualization was additive, not a substitute -- substitutive, I should say, that it was value-added and that we were going to have the demonstration project idea whether it was in primary, you know, a designated primary care provider under the current definition in place, and this was going to add to it, because what we didn't want to say was that naturopathic medicine in a rural community would constitute the equivalent of having a family practitioner there or internal medicine person there. I mean, they do two different things.

DR. GORDON: We need to move along. My memory is that we did talk about those kinds of demonstrations and that this is a somewhat separate issue, because we also talked about the possibility of loan forgiveness for CAM practitioners. It is both true.

We need wording on this, and I think Wayne has some wording.

DR. PIZZORNO: Wayne, Tieraona and then Effie.

DR. JONAS: Here is my suggested wording. "The Commission recommends expanding the eligibility of CAM students to participate in existing loan and scholarship programs and CAM practitioners to participate in loan forgiveness programs when appropriate, when or where appropriate, however you want, when or where appropriate."

DR. GORDON: Can we move ahead with that one?

DR. PIZZORNO: Yes, I think that is great.

DR. GORDON: Can we get a consensus? I want to push. We are cutting into our lunchtime, and we want to have time for digestion.

DR. FINS: Good recommendation because it achieves the objective of the students, it doesn't entangle it up with the primary care definition or the Title 7 question. So, I think it's on target.

DR. GORDON: Do we have a consensus on this one?

SISTER KERR: Yes.

DR. GORDON: Okay. Let's go with that. Excellent. Let's move on to the next one.

DR. PIZZORNO: Thank you all.

Number 50 or No. 8 depending upon which one you are looking at. "The Commission recommends that a core curriculum of knowledge about CAM systems, modalities, therapies, approaches, fundamentals and principles should be developed in conjunction with CAM experts and CAM institutions based on minimal knowledge-related competency and designed with maximal latitude for ease and cost-effective implementation at conventional health professional schools and postgraduate training programs and in continuing education programs to increase knowledge and understanding of CAM, so that conventional health professionals can discuss and provide guidance for the appropriate use of CAM."

It's a little long, I agree, but is everybody okay with the concept?

[No response.]

DR. PIZZORNO: Okay.

Going, going, gone. Thank you.

DR. GORDON: Okay. Are we all right with that one? All right.

DR. BERNIER: One last one.

DR. GORDON: No, and then we have got mine.

DR. BERNIER: The ninth one. "The Commission recommends that demonstration projects of joint primary care residency for appropriately educated and trained CAM practitioners and conventional physicians should be conducted to determine the feasibility of such residencies and their impact on collaboration, clinical competency, and quality of health care."

I might be able to divert some of what we are going to just say by suggesting one slight change in the introduction, and that is, "The Commission recommends that a core curriculum of knowledge about CAM systems, modalities, therapies, approaches, fundamentals, and principles" -- I'm sorry, skip that, wrong one.

"The Commission recommends that demonstration projects of joint residencies," and remove "primary care" from it. So, it would say, "The demonstration projects of joint residency for appropriately educated and trained CAM practitioners and conventional physicians conducted to determine the feasibility of such residencies and their impact on collaboration, clinical competency, and quality of health care."

DR. FINS: We can't have joint residency programs for people who are coming out of a naturopathic medical school and the allopathic medical school. I mean, it just doesn't match. What I think we might --

DR. PIZZORNO: We already do.

DR. FINS: Where, who accredits it?

DR. PIZZORNO: We have two going on right now at conventionally accredited hospitals. Sorry, it is already happening, and it's working great.

DR. FINS: What kind of accreditation do they get at the end, internal medicine, and they get double boarded?

DR. PIZZORNO: I just know they are happening, I don't know the details.

DR. FINS: I think we need to know the details. I think what might be very helpful is to -- you know, you have two pools of residents. You have got naturopathic, basically, you are talking about naturopathic residencies.

DR. PIZZORNO: We are talking about all of the appropriate qualified CAM professionals, not just naturopathic physicians, those who are licensed to

practice in their states.

DR. LOW DOG: So, a massage therapist's who is licensed should do a residency.

DR. PIZZORNO: Massage therapists are not licensed to diagnose and treat.

DR. LOW DOG: Okay, but that is different than what you just said about licensed.

DR. PIZZORNO: Okay, licensed to diagnose and treat, how is that?

DR. BERNIER: Effie.

DR. CHOW: Thank you. I think we need a definition of primary care. This goes back to multiple discussions before, and that we keep getting into a problem when we say primary care.

Do we really mean just the medical doctor of primary care, or do we mean that there is an expanded definition of primary care? We are going to run into all this discussion every time we come to primary care.

So, I recommend that be done. Recommend that primary care be defined, so that there isn't this debate about that. I know acupuncturists do primary care in California, and naturopath, you know, are primary care.

Now, chiropractors, are they primary care?

DR. GUTIERREZ: In some definitions, they are.

DR. FINS: Not the federal definition, because you don't vaccinate, right?

DR. CHOW: It needs clarification.

DR. GORDON: I think primary care, the conveners, the facilitators have already stricken that from this, is that correct?

DR. LOW DOG: Yes.

DR. GORDON: I have a more fundamental question I would like to raise. I think that what I would like to focus on is residencies advance training for CAM professions, period, not that I am against the possibility of joint residencies.

To me, the real absence is in advance training, whether it is for naturopathic physicians or acupuncturist or massage therapists, all of them, they don't get the kind of advanced training that is so easily available to us as M.D.'s or D.O.'s.

So, I would recommend that this recommendation be changed to emphasize demonstration projects of residencies for appropriately educated and trained CAM

practitioners.

Then, I would say, "Demonstration projects should be conducted to determine the feasibility of such residencies and their impact on collaboration, clinical competency, and quality of health care."

DR. BERNIER: That's great. I wish I had said that.

SISTER KERR: I have a comment.

DR. GORDON: Do we have consensus on that one?

SISTER KERR: I appreciate that clarification. Even though I know people want to hear Effie say, you know, we need the primary care definition, I think this area, we are not congruent or together enough on this because, for example, for myself, those complementary medicine practitioners who can diagnose and treat, I think are few, and I only know naturopathic, some chiropractic, I think some acupuncturists as defined in California are under primary care, whereas, we aren't, so in a way, if the goal is to look at how those who are licensed can all -- what Jim is saying, that makes more sense to me, but if there is another reason for how this is written, maybe we can look at that or see what the

need was, or maybe somewhere else.

DR. GORDON: Joe, why don't you go ahead.

DR. FINS: I hate to bring this up because it is sort of a parallel complexity, but if we call these things residency programs, then, the pool of money, instead of being -- the other pool of money is GME money, right? So, it is a parallel problem because, in a pool of money, we are saying now traditional residency programs --

DR. GORDON: Let's call it postgraduate programs.

DR. FINS: Well, I think it is going to be the same issue.

DR. GORDON: Postgraduate training.

DR. LOW DOG: I think postgraduate training, it should be made available, and I am not sure the funding part is real essential, because you can go to postgraduate, you know, I mean, my son will be going, so he is going to take out loans like everybody else does to pay off.

But I think that the point here is that advanced training be available and that people who want

to continue on in their profession, it sounds like the chiropractors have a diplomate in nutrition.

There has been expansion, so that there is room for further training, and I think that -- I know that the naturopaths many times, the students who have come to our clinic have said that they wanted residencies, that they wanted more training, so I think we don't have to get into the funding, but I think we should -- one, I would stay away from joint, I would agree with that, and, two, I think that there should be advanced training or whatever word you want to use.

How that is going to happen, I am not sure, you know, people are going to have to develop the curricula for that, and what would it look like, I mean, so that is more under the education, that I would like to see.

DR. GORDON: I just think it is really important for us to take a stand, and this is what we have heard again and again from practitioners, and I have heard over the last 30 years, we want to learn more, and I think that we should take a stand that they should have available to them without, as Tieraona says, we are not making a comment on funding.

DR. FINS: We just call it advanced training, and not residency? Why do you want to call it residency, Joe?

DR. GORDON: Let's call it postgraduate training.

DR. FINS: Why do you want to call it that, Joe?

DR. PIZZORNO: We need residencies because it is the appropriate language for the next level of training that postgraduate practitioners get, and we also have some state laws that are now mandating it in bilanguage residencies.

DR. TIAN: I think that joint is not the word that we want to use because it confuse. What is a major especially the resident for internal medicine or family practice, and you just want to add some information or education program or some kind of course introducing CAM to the resident.

DR. GORDON: This is a somewhat different issue, though.

DR. TIAN: Right, but again, the "joint," I think we don't have a standard, mention a standard for

joint program, and we have no position to do that. So, a joint program for each hospital, they would decide by themself, so I would say remove "joint."

DR. BERNIER: Okay. Joe had put together, if you just hold for a second, a modified position.

"The Commission recommends that demonstration projects of residencies for appropriately educated and trained CAM practitioners, they should be conducted to determine the feasibility of such residencies and their impact on collaboration, clinical competency, and quality of health care."

DR. GORDON: Just change that by putting, "clinical competency and quality of health care first, and collaboration last, because collaboration is less significant in this issue, the way we have reworded it.

DR. BERNIER: Are you comfortable with that?

DR. LOW DOG: Can I ask a question? I mean, you want a demonstration project to see if more training does you good? I mean, there has to be a demonstration project, you couldn't -- I don't understand why we are asking for a demonstration project if we changed it sort of for residency.

Maybe you could help me by what we are trying to get at with this recommendation, what is the underlying question that we are trying to answer with this recommendation, because I have a feeling it is trying to do something that we have not clearly stated.

DR. BERNIER: Joe?

DR. FINS: Tieraona, I think the point here is that when you do call this a residency or postgraduate training program, it begins to open the possibility of entitlement to fund those programs through the GME revenue stream.

I guess the idea is to do this incrementally, to have a demonstration project to see whether or not that would be something that should be funded, and here, we are funding it at a smaller level, having some demonstration projects to get the bugs out of the system, to figure out if it works, to figure out how long it should be before it would then modify or have to augment a GME funding stream.

I think it would be a huge step to say GME should fund residencies in CAM because we don't know what is diagnose, what is treat, so it's an incremental step

to collect to collect information on the graduates, the training programs, you know, what will be the residency review committees, and how would you accredit these bodies. There are a lot of questions that are left to be answered, and that is why I think a demonstration approach is the incremental step.

DR. BERNIER: Tom.

MR. CHAPPELL: I am just thinking that leaving this to the marketplace is the best approach, that I don't really see anything here that a Commissioner should be trying to recommend.

DR. BERNIER: So, you would have it deleted in total?

MR. CHAPPELL: I would delete it, yes.

DR. GORDON: I would say I think it is an important recommendation for us to make. I think we are giving a kind of academic, we are sort of lending our imprimatur to encouraging people to gain some of experience and academic respectability, and I think it is an important stand for us to take.

MR. CHAPPELL: Then, I think we have to stop watering it down, because the intent of this was clear,

and we keep on taking the original intent out, and it is leaving it with, as Tieraona said, what are we left with here that we are recommending.

I think the real point is that this is going on in the marketplace right now. There is an incentive for these joint residencies to take place because the consumer wants it, and because the professions want to learn from one another.

DR. GORDON: Tom, I would just say that, in fact, there is very little in the way of joint residencies, very little at all, and there is very little in the way of sort of intensive, even though there is short-term training, but the kind of residency that we have for three or four or five years is just not available at this point.

I see it as a step that needs to be taken by these professions, so that if you are a chiropractor, what about working in a hospital or a health center for a couple of years and really being part of that? Chiropractors used to be able to work in hospitals, right, and do residencies in hospitals. They are no longer doing that.

I am saying that we need to take this step before we are so concerned about joint residencies, that's all.

I am also saying that we need to come to a conclusion very quickly, too.

DR. CHOW: I think this is a very important item, and I would recommend that we take out the demonstration project and just put, "The Commission recommends that residencies for appropriately educated and trained CAM practitioners," et cetera, et cetera, et cetera, just take that out and make it straightforward, and if a demonstration project is to be done, that is the process later, we don't have to recommend that.

DR. BERNIER: Are there others that share that view?

DR. ORNISH: No, I don't share that view at all because the presumption in that recommendation is that it has already been proven to be a good idea, and the whole point of a demonstration is to see if it is a good idea.

DR. KACZMARCZYK: I would like to speak to Joe Fins' concern about GME funding. Most GME funding comes through a formula-derived basis, but there is one

exception to that, and that is appropriations funding, which is how, for example, children's hospitals are funded. So, that is one mechanism that has not heretofore been mentioned.

DR. FINS: I would respond to that. We don't know how much to ask for, we don't know what the need is, so demonstration projects is an incremental step in that direction.

DR. GORDON: Can you restate the recommendation that you have come up with based on seeing what is happening around here, and see if we can live with it?

DR. PIZZORNO: I am just going to read what George just read, and also state that I think demonstration projects are a good idea, because not only do we want to prove efficacy, but there is a lot of details to be worked out about how to do it properly. We need to work on how to do it properly before we get into huge-scale projects.

"The Commission recommends that demonstration projects of residencies for appropriately educated and trained CAM practitioners should be conducted to determine the feasibility of such residencies and their

impact on clinical competency, quality of care, and collaboration."

Do you want me to read it one more time? Okay.

"The Commission recommends that demonstration projects of residencies for appropriately educated and trained CAM practitioners should be conducted to determine the feasibility of such residencies and their impact on clinical competency, quality of care, and collaboration."

DR. WARREN: Did you leave in "joint"? You want it to be between the conventional and the CAM.

DR. GORDON: I think for us to recommend joint when there are virtually no residency programs is really going way ahead of where the field is.

DR. PIZZORNO: I think the ideal world would be a chunk of money, different groups get together and say here is how we would like to do it, give us some money, and let's try it out and see how it works. They may be joint, they may be independent, there is lots of different pathways.

DR. FINS: And it is implicit in the word "collaboration," you know, the impact on collaboration,

and I just want to say just as a parenthetical the text justification will reflect our conversation, because the text reflects the older recommendation, so that also has to be reworked.

DR. BERNIER: Dean.

DR. ORNISH: I hesitate to say this because I know it is going to sound pretty radical and probably will earn me the enmity of at least two-thirds of the people on this commission, but having that as a context, you know, it just seems to me that there is sort of a logical progression of things.

First, you show something works and then you show how to try to train people in it and how to make it more widely available, and things like that. While I personally believe that a lot of CAM modalities have great benefit, there has not been, as I think we have heard from a number of the 4,000 people who have testified, a lot of evidence, proof for that yet.

So, to me, the biggest land mine of all is when we start recommending that the government pay for loan forgiveness, for training programs, for things like that, to train people to do what yet hasn't been proven to be

scientifically effective or cost effective, I think we are getting ahead of the curve.

Tieraona, did you have any thoughts about that?

DR. LOW DOG: I sort of separate them into two issues. One is that I think that funding should be available for education. You know, my son can take out loans to study whatever he wants at an accredited institution, and so I don't think that should be exempted.

I think if you are going to massage school, if you want to take out a loan, I think that should be available to you, because I think education is important. You can get it to go to cosmetology school, so I mean, I don't think it should be singled out.

I do think that this is a tricky issue, though, when we start getting into advanced training and loan forgiveness, when we have yet to determine if that modality actually does what it claims to do, and I think that is a sticky issue, but I separate them out.

I think that fundings and loans should be available to people whatever they are studying. I think that people have the right to do that.

I think it is a different statement when you say we are going to forgive loans or we are going to provide money or that we are going to take from one pool to another for yet-to-be-proven therapies.

DR. BERNIER: Could we look and see what kind of support we have for either keeping it as it was modified by Joe?

DR. ORNISH: Just to clarify one last thing, because I haven't really said much this session, what I would like to see almost throughout the whole document is something that say for modalities that have been or will be proven to be efficacious, safe, and effective.

It is great to fund demonstration projects to find things out or better research studies to find things out, but if we can qualify things to say for things that are safe and effective, it certainly claims the middle or high ground and marginalizes critics, because you say, well, why wouldn't you want to have things available if they are safe and effective, but if you presume that things are safe and effective when they aren't, it leaves us wide open to what can often be legitimate criticism, and that is something I would like to avoid.

DR. BERNIER: So, Dean, do you want to keep something in there?

DR. ORNISH: Well, I think you can keep things in there if you can qualify them by saying, you know, for example, I mean, almost any of these recommendations if you say "for modalities that are shown to be safe and effective."

You don't even have to get into what level of evidence we are talking about, but at least that there should be some evidence, and you can argue about how much later, we don't have to get into that debate here, but just to say whatever the recommendation is, "for modalities that have been shown to be safe and effective," period.

Then, you claim the high ground, you marginalize critics. You say, "Well, why wouldn't you want to pay for something if it is proven to be safe and effective," but if you presume that things are safe and effective, when they haven't yet been shown to be, you leave yourself wide open, legitimately so.

DR. BERNIER: Joe, you had a comment?

DR. FINS: There are all kinds of questions

that follow from what Dean says. I mean, should residency programs be for people who have a doctoral degree? What are the standards? I mean, "appropriately educated and trained," I mean, you know, there are very strict criteria about what qualifies someone to be eligible for residency programs.

DR. ORNISH: In the same breath, it is the same thing, it is like you want to be in a residency program with a modality that has been proven to be safe and effective.

DR. FINS: That's right, but I guess what I am saying, it is a double-edged question, it is not only safe and efficacious practices, but also appropriately trained individuals.

DR. GORDON: What I would like to do is to hear the wording and see if we can live with it, and if you want to amend it in some say, as Dean is suggesting, that's fine. I feel like we need another rendition of the wording, and if people feel strongly about what Dean or Dean and Joe were saying, let's get that in the wording, let's vote it up, down, or send it back.

DR. ORNISH: Jim, just to finish the thought, I

am talking about this one recommendation.

DR. GORDON: I understand.

DR. ORNISH: I am talking about across the board.

DR. GORDON: I understand, but we are dealing with -- we can come back to that, but we are dealing with this recommendation right now, too. So, this is a trial example of whether or not the wording should be in.

I think we should come back to that, Dean, I am not dismissing it in any way. I am just saying we need a decision on this particular one, as well.

DR. PIZZORNO: It seems like there should be like a preamble, a couple of sentences that says what Dean says, because I think what Dean is saying is correct, but we can't put "safe and effective" in every one of our 100 recommendations.

So, there needs to be some kind of preamble.

DR. ORNISH: We had this conversation on one of our conference calls, and I actually think you can put it in every recommendation, I think it makes it stronger if you do, because I can tell you this, these recommendations are going to be taken out of context by

media, by other people, and it should be in every one of these recommendations, and if it sounds like it is a redundant mantra, so be it, but there is nothing wrong with it. It only makes us much more safe and protected.

DR. GORDON: Let me just second that because I think there are also CAM practices that we don't know if they are safe and effective, and we may have opinions about how those should be addressed, as well, if you understand what I am saying.

People need information about CAM practices whether or not they are safe and effective, but as far as a residency program or inclusion for payment, and we have this in the Reimbursement section, safe and effective words are in there all the time.

So, could we have some wording on this, Joe?

DR. PIZZORNO: I will take a shot at it. It raises quite a can of worms here.

"The Commission recommends that demonstration projects of residencies for appropriately educated and trained, safe and effective CAM practitioners be conducted to determine the feasibility of such residencies and their impact on clinical competency,

quality of health care, and collaboration."

DR. GORDON: Practitioners are not safe and effective.

DR. PIZZORNO: Right.

DR. GORDON: It's the practices.

DR. PIZZORNO: Well, they should be safe and effective.

[Laughter.]

DR. ORNISH: It's for CAM practitioners in modalities that have been shown to be safe and effective.

DR. PIZZORNO: Who decides what is safe and effective?

DR. ORNISH: Well, we don't have to get into that debate of what is considered safe and effective or what level of proof is needed. That is talked about in other places. But as a concept, I think we can at least all agree that the modalities should be safe and effective.

If there is no evidence that something is safe and effective, why would you want to put someone through a residency program and train them to do it?

DR. PIZZORNO: Because it's the best knowledge

that is available at the time.

DR. ORNISH: Well, that's not good enough for the government to pay for something.

DR. PIZZORNO: Why don't we go back in conventional medical education training and decide which of the then unsafe and ineffective therapies should not have been taught in residencies?

DR. ORNISH: But, Joe, that is a specious argument because it is like two wrongs make a right.

DR. LOW DOG: I want to go eat.

DR. ORNISH: Let me just finish here because this is a really important issue to me. The fact that a lot of traditional medicine does things that are not safe and effective, shouldn't be, well, gosh, you are not safe and effective, why do we have to be.

I think we should say and part of our report should be that the same standards should be held to conventional medicine, which also doesn't live up to that.

DR. PIZZORNO: Dean, I 100 percent agree with you, but the reality of the situation means that we end up with a double standard because --

DR. ORNISH: No.

DR. PIZZORNO: -- conventional is already in and CAM is not.

DR. ORNISH: No, I am saying that we want to say in our report that we don't want there to be a double standard, we want this to apply to both conventional and nonconventional, and they both need that, and they don't have it, and by having a level playing field, we are talking about something that is very fair and very equitable.

DR. PIZZORNO: Tom.

MR. CHAPPELL: I think, Joe, the editing of your language could be simple here, and that would be, in the last line, "clinical safety and efficacy."

"The Commission recommends that demonstration projects of residencies for appropriately educated and trained CAM practitioners be conducted to determine the feasibility of such residencies and their impact on clinical safety and efficacy, quality of health care, and collaboration."

DR. PIZZORNO: Tom, I appreciate your wording, but I don't think that gets to the issue that Dean was

addressing.

DR. ORNISH: It is not hard to come up with wording. You just say with every issue that comes up here, every recommendation, you know, or most of them anyway --

DR. PIZZORNO: So, this is the wording that I think Dean is proposing: "The Commission recommends that demonstration projects of residencies for appropriately educated and trained CAM practitioners of safe and effective modalities" --

DR. ORNISH: -- "of modalities that have been shown to be safe and effective" --

DR. PIZZORNO: -- "of modalities shown to be safe and effective," et cetera.

DR. ORNISH: Right, et cetera. You can use that, "modalities that have been shown to be safe and effective" can be put in, in almost any recommendation, and I think it is going to make them much stronger.

DR. BERNIER: Joe.

DR. FINS: We are still left with a question about when you are at a point when you have enough to have a residency program, and if you look at, say,

neurology, since we in the NINDS building, neurology grew out of internal medicine, and at a certain point, they looked around and said, you know, we have developed a new field, a new specialty within an old specialty, and it kind of morphed out of that.

So, the question is, you know, I think we need to also say something about established professions or, in other words, we have a taxonomy of various kinds of professions in and Access and Delivery section.

A residency program configuration would be inappropriate for some less evolved CAM practices or practitioners, and somehow in the language I would like it to say for the more evolved.

DR. ORNISH: But, Joe, if you have a modality, no matter how young or how old it is, that is safe and effective, then, why not have a residency for it?

I mean, I think that is really what it comes down to, you know, the fact of neurology rather than internal medicine, if neurology had been shown to be safe and effective earlier on, maybe they would have done a residency. I mean, I just want to keep it simple, and then we don't have to get into the level of evidence that

is required. We just have to put it out there and let other people figure out what the level is.

DR. BERNIER: Tieraona.

DR. LOW DOG: Last comment because I am hungry.

DR. GORDON: One more recommendation, too.

DR. LOW DOG: Oh, Lord. I feel that I want to somehow give voice to some of what Dean said, because, one, I think that we don't talk enough in this commission, and it is not represented enough in this document, some of the down sides or some of the ineffective.

We haven't taken it on, we have not taken on what even many people around this table would probably think are unsafe and probably not effective therapies. We don't talk about it, maybe it is not politically correct, so we just have avoided it.

I think it is a weakness that we weaves throughout the document by not giving voice to that, and that some of these, it is not just political marginalization that has occurred. I think part of this has occurred because some of these probably aren't that effective, and some of them probably aren't that safe.

So, I would echo putting safe and effective and therapeutically effective. I think that we need to have that strong throughout the document, and I think we need to perhaps have a little more courage to come out and say where we think that there are some problems.

DR. GORDON: I think that is perfectly appropriate and in the recommendations, Tieraona, I invite you and others to insert those where appropriate, and we can, I think just as we were talking about the history, that we are kind of filling some of those elements, so thank you.

We need to move ahead.

DR. BERNIER: I would call the question on No. 9.

DR. GORDON: That is the recommendation.

DR. BERNIER: As modified.

DR. GORDON: Veronica, can we live with this?

DR. GUTIERREZ: I would like to hear it one last time.

DR. BERNIER: I will read it one last time.

"The Commission recommends that demonstration projects of residencies for appropriately educated and

trained CAM practitioners of modalities shown to be safe and effective should be conducted to determine the feasibility of such residencies and their impact on collaboration, clinical competency, and quality of health care."

DR. FINS: I think you wanted to have clinical competency first.

DR. BERNIER: Yes, clinical competency first.

DR. GORDON: Right. Collaboration is at the end of that.

Can we live with this one?

[No response.]

DR. GORDON: Good.

DR. BERNIER: Thank you for your kindness.

DR. GORDON: This is a recommendation that I am making, that is very much in line with the principles, and it was there, very strongly, in the October meeting, and somehow may have been assumed, but got left out.

"The Commission recommends that programs of conventional and CAM professional education include the teaching of self-awareness and self-care, and their use in promoting health and treating illness."

DR. BERNIER: That is a recommendation?

DR. GORDON: A recommendation in Education.

DR. FINS: Without the Background section, we should probably deal with it the next time, because we need to see why.

DR. GORDON: Because it is absolutely there in the section, it is just not made as a recommendation. I will explain to you why. The reason why is that I think one of the most important changes in medicine and health care, and one of the most important contributions of CAM, is going to be encourage people to take care of themselves.

Unless professionals learn about self-care, their patients are never going to learn it. So, I feel very strongly it needs to be in the Education section, as well as when we talk about self-care in the Wellness section.

MR. CHAPPELL: Could you repeat it?

DR. GORDON: Yes. "The Commission recommends that programs of conventional and CAM professional education include the teaching of self-awareness and self-care, and their use in promoting health and treating

illness."

MR. CHAPPELL: I think it's not there yet.

DR. GORDON: Oh, it's not there.

DR. BERNIER: Who is the teaching to go to?

DR. GORDON: Programs of conventional and CAM professional education, so all those students in CAM and conventional professional education school.

DR. JONAS: I agree that this is a core aspect of our guiding principles, and it is a core aspect of medical education reform, and I would second adding that to this as an additional recommendation.

MR. CHAPPELL: I agree.

DR. GORDON: Do we have consensus on this?

[No response.]

DR. GORDON: Then we have lunch.

[Lunch recess taken at 12:34 p.m.]

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

[1:00 p.m.]

DR. GROFT: You may or may not want to do this, but I wanted to at least propose it to see if it was a feasible way. Maybe this is not the final answer, whether it would be a feasible way of grouping the recommendations. So that, if we end up with 85, we don't have 85, but we may have 15 or 18.

I just wanted to offer it as a possibility, something we have thought of and we may not even be able to discuss it today, but perhaps tomorrow, or at some other point in the very near future, to think about it.

DR. GORDON: Let me make another point along with that, is this should not exempt us from cutting down or compressing recommendations, that wherever we can do that, if there are half a dozen recommendations around the same issue, let's try to compress them.

What this effort that Steve and the rest of the staff have been doing is really, what is the best way for us to present what we have been doing in a way that is concise enough and directed enough so that people will get what we are up to and will understand what we think

is most important.

Now, there are going to be a number of ways to do it, this is one way, but I think while we are doing -- and please look at what they have done, but while we are working today, please also be thinking of how to compress and condense, and we have done a little bit of that, and I think that is great, but not repeating something in two different or three different sections where it doesn't need to be there.

DR. FINS: What do you do with the text?

DR. GROFT: The text continues to grow. The text will continue, it will be expanded, and all the recommendations map back to one of these major concepts, so we can trail them. The text will change as we would normally do it, as we prepare the final report.

DR. FINS: I like this very much. What I don't understand is, there is a chapter on Education that we just did. That chapter will still be there.

DR. GROFT: Yes.

DR. FINS: This recommendation, Action Item 1.1, so this is just clustering?

DR. GROFT: Clustering the recommendations into

action items.

DR. FINS: This could also be the executive summary.

DR. GROFT: It would be the start of an executive summary, right.

Tom.

MR. CHAPPELL: What I have been looking for, because we need to anticipate that we are going to have readers of these documents, and this rationalizes the work into some categories of thought that I think will be very persuasive and powerful.

I definitely have been looking for something like this and I want to encourage it.

DR. GROFT: We were listening, and I was trying to figure out what we could do. Linnea sent us a document, and then it hit me, gee, we can combine several of these things into a workable document that will make sense. Tom is right, we have so many different audiences we have to play towards and get the message to that we do have to simplify somehow.

I am not saying that these concepts and these recommendations that we provided are absolutely 100

percent correct, but I think just the idea if this is a way that you would like to go, we would then consider this for the final report.

There may be a need for more recommendations, but I think we heard all along that people would like to reduce the number of recommendations down, but I want to make sure that we are capturing your thoughts and concerns with this idea and these concepts that were put forth as recommendations.

DR. GORDON: But I think what is crucial right now is just keep this as one possible schema. We very much have our task in front of us and understand that we may present different ways of organizing the material. We don't really want to focus on this, just Steve wanted to make sure that everybody had this available to them.

DR. FINS: Did some things move? There were some action items that might have been with Education and Coverage and Reimbursement, that we created a new category. Or, are they pretty much still where they were?

DR. GROFT: They did not migrate at this time, but they may migrate later on as we refine the report and

the recommendations even more, like we talked about some that really should have been in Access, so they are going to migrate out where they were and into the Access section.

DR. FINS: The real beauty of this really is that everybody -- I mean, I haven't read through it -- but everybody can probably agree on what is in the bold print.

DR. GROFT: Hopefully, so, yes, that is the idea. We do have the opportunity to expand the number of recommendations by several more if they are the major concept that we want to convey.

DR. GORDON: The problem is the same. The problem is that the recommendations may not be strong enough if we try to reduce them to these general categories.

We are just presenting the pros and cons, and we really need to come back to this later because everybody needs to take a look at it and see how it serves. Then, we can come back and have a much fuller discussion.

DR. FINS: When we go back and write the final

version of the thing other than the introductory chapter and the Principle and the History chapter, this could be like the executive summary, and then for each of the action items we just have a bullet of justification or rationale.

In other words, I think one of the problems that I think we have to determine is the big wind up on the Background section, and then the recommendations which may or may not make sense to the reader versus having the reader get the action item and then the rationale right there, so they can see how it links up.

DR. GROFT: We are wrestling with that, too. It may be a peculiar problem to Access and Delivery where so much is presented before you get to the recommendation as opposed to the other sections, that things are stated and then recommendations follow it, but it is something we want to talk about a little bit more.

DR. GORDON: What I would like to do is talk more about -- we are going to talk more about where we are headed tomorrow -- I want to just mention a couple of other things. This is really in the spirit of mentioning coming attractions.

There are two sections that we haven't organized, and again, we will come back to this tomorrow because we really need to start momentarily, one is there is a vision section at the end that will sort of be what is the vision that comes out of this whole report, and that is not going to be a very long section, but it will be a section.

One of my thoughts was if there is a group of people who are interested in that section, I could do a first draft and then work with people on that section. So that is just something to think about, we will come back to that tomorrow and then people can critique the section and we can go through it.

It will come out of what we have here, what we come up with on recommendations and text, and then it will go out after the group has massaged it, it will go out to everybody, and then it will come back and we will work on it again.

The other piece that I want to ask people about tomorrow is whether or not you saw there are two recommendations which are not fixed in stone obviously in any way about the response to 9/11, and I want to have a

discussion tomorrow about whether we should be addressing issues related to 9/11 at all, and go from there. We will do that at lunchtime tomorrow.

Anything else, Steve, that we have to give a preview about?

DR. GROFT: No, I think that is it.

One last thing, we are going to change the afternoon sessions today. Dean has to go tomorrow over to HCFA, and so we will move the Coordination of CAM Research, which was Session VI, to the first session this afternoon, and we will move Access and Delivery that was scheduled this afternoon until tomorrow morning at 10:00.

The section on Wellness and Prevention scheduled at 1:00 tomorrow will be moved to 3:15 today, and then we will flip the Coverage and Reimbursement until tomorrow afternoon.

So, we are moving Session VI, Coordination of CAM Research, to the next session, that will follow lunch, and we will move Session VII, which is CAM in Wellness and Prevention, that was scheduled for tomorrow at 1:00, into the session for today at 3:15, and then those two sessions, III and IV, that were to be held this

afternoon, will be moved to 10:00 tomorrow morning and 1:00 tomorrow afternoon.

DR. GORDON: We really need to begin because we need to give the sections adequate time.

DR. GROFT: Everybody tonight, for dinner, is pretty much on their own. I think the feeling was that people are pretty well worn out. I don't know about you guys, we are tired, too. We just said just go ahead and enjoy the evening on your own and relax, and we will get together in February.

DR. GORDON: Is everybody with us on this? We are going to be meeting in February, and either the second or third week, is that our plan?

DR. GROFT: Somewhere around the 20th or 21st.

DR. GORDON: Everybody has got to check their schedule for third and fourth week.

DR. GROFT: Yes, about the third or fourth week.

DR. GORDON: Let's begin now with Research. We will be discussing this tomorrow. This is just time to go back and check your calendars between now and tomorrow, and then we will come to a decision.

Dean, do you want to begin?

Session III: Coordination of CAM Research

DR. ORNISH: First, let me say I want to thank Jim and everyone involved in switching the order. I have had some unexpected issues come up with Medicare that I am having to deal with that are really consuming me, so the irony is not lost, believe me, on all this, so I really, really appreciate and apologize for any inconvenience that this may have caused anyone, but thank you.

So, why don't we just get right to it. If you all can open your bibles to Chapter 7. We are talking about the coordination of research. I think Wayne is supposed to join us. Also, we have the resolutions which begin at the very beginning under the first section.

I think that probably the easiest say to do this, we can go through the text, but it might be easier to just focus on the recommendations and then use the text as a backup to any clarification or issues that people might have.

I have to say that some of the recommendations, Wayne and I, were new to us, so we may have comments on

these, as well as you all do, but let's start with the first one.

DR. GORDON: Dean, excuse me, the question is are there any other recommendations, gap recommendations or new recommendations. I have one that may be answered as we go through this, but if not, I want some time at the end.

Does anybody else have any recommendations, gap recommendations?

[No response.]

DR. GORDON: Okay.

DR. ORNISH: Just speak up and make sure we know that, so we don't leave it out.

The first recommendation is that the Commission recommends strengthening the emerging dialogue between conventional medicine and CAM by continuing to develop ways to enhance communication, cooperation, and collaboration among conventional and CAM research and clinical professionals, research centers, and accredited institutions, professional organizations, and federal and state research and health agencies, the profit and nonprofit sectors, and the general public, and the whole

wide world.

Any comments of questions about this particular point? Bill.

DR. FAIR: I like the suggestion. My basic philosophy is that the fewer number of recommendations, as Jim said, and the shorter the recommendations, the more likely they will be read, so I was wondering what you would think about just having: "The Commission recommends strengthening the emerging dialogue between conventional medicine and CAM," period, and then put the rest of the stuff in the discussion.

DR. ORNISH: I like that. All in favor, aye; all opposed. No. 2.

DR. JONAS: Since this is in the Research section, this should be about collaboration around researchers and investigators, so we should have words to that extent, and I don't mind what you just said, however, what I would suggest is we just add "conventional and CAM researchers" or "investigators," period.

DR. ORNISH: Good. That is a nice one to start with in that way, because it sets a tone of dialogue that

we are trying to build bridges.

DR. FINS: How about researchers?

DR. ORNISH: Well, researchers generally have come from someplace.

DR. JONAS: Investigators and institutions.

DR. ORNISH: Researchers and research institutions.

MS. POLLEN: May I say something?

DR. ORNISH: Yes, you may.

MS. POLLEN: Then, you are really limiting it to just researchers or clinical professionals. All researchers will be clinical and basic.

DR. ORNISH: I mean, in a way we are also talking about strengthening the emerging dialogue between clinicians, and so on, but that is a different section. So, if we want to say to the topic here.

MS. POLLEN: You are leaving out the federal and state agencies.

DR. ORNISH: We are leaving out everything.

MS. POLLEN: Everything else, so you want all of that just in the text.

DR. ORNISH: Yes, it's implicit, and if

somebody really wants to read the rest of it, they can.

DR. GORDON: Are you leaving in "clinicians"?

DR. ORNISH: No.

DR. GORDON: I think that is important, the reason being that many clinicians are kind of wondering how to do research, especially CAM clinicians, but also conventional clinicians who want to do research on CAM.

DR. JONAS: We are not leaving out anybody in this first recommendation. We are actually shortening it, so that we can include everybody. Later on, in later recommendations, we specifically address the issue of clinicians.

DR. GORDON: Fair enough.

DR. JONAS: Just for this first recommendation, it is just in the spirit of --

DR. ORNISH: It sets a nice tone for everything that follows.

DR. FINS: We might simply say, "conducting basic science and clinical research" as a phrase to be put in there to show that it's a comprehensive approach.

DR. ORNISH: I think once you start getting more specific, then, it becomes more glaring what you are

omitting. I think if you just make it a general thing, and then the other recommendations, we do get pretty specific about that.

If you find that we haven't covered that in the later recommendations, then, we can come back to this. But there is something nice and short, people can read this and it is not overwhelming, and it is not a long run-on sentence like it is now.

DR. PIZZORNO: Could you read the final version?

DR. ORNISH: Wayne.

DR. JONAS: "The Commission recommends strengthening the emerging dialogue between conventional medicine and CAM, investigators, and institutions."

DR. ORNISH: Issue No. 2. "The Commission recommends that standards of quality for all aspects of research and related activities be the same for CAM as for conventional medicine."

This is a particular pet issue of mine, as you all know, because I think it really levels the playing field, it appeals to the fairness of the American people, and it forces critics to say, oh, no, we think that it

should be held to different standards, which is much harder position to defend.

Any problems with that? Joe.

DR. FINS: Scientific standards?

DR. ORNISH: It's not just scientific standards. It's everything. Again, we are going to get into that more later. We are trying to kind of set a tone early on and then get into the details later, but again, it is a good thought. Keep the thoughts of it. If we don't address it adequately later, you can raise it again.

Any opposition to this?

[No response.]

DR. ORNISH: No. 3. "The Commission recommends that research journal, regulatory and health insurance advisory and review committees in both the public and private sectors include, as needed, trained and qualified CAM and conventional professionals, and recommends adopting, as appropriate, any regulations that might impede such representation."

Comments?

DR. FAIR: I think it is a good recommendation.

I was trying to figure out, since journals are private, generally privately run, does anybody have any ideas about how one would increase the input of CAM providers on journal editorial boards or anything like that? Is there any way to go about that?

DR. JONAS: Are you just asking for some general thoughts about how that could occur?

DR. FAIR: Yes. How could we actuate that suggestion?

DR. JONAS: We could recommend to them.

DR. ORNISH: Actually, the sentence is not really saying what it is intending to say. It really actually should say "and recommends adopting, as appropriate, any regulations to avoid impeding such representations."

I am not entirely comfortable myself with that last part of it, about the regulation part, because I think that gets into an area where people say we don't want the federal government dictating to private journals who should be on their boards, and I would support that actually, so my recommendation would be to end the sentence after, "and conventional professions," period.

Are you all comfortable with that? Okay.

Number 4. "The Commission recommends independent or collaborative support by the public, private, and nonprofit sectors to organize multidisciplinary conferences on CAM research, to increase opportunities for CAM and conventional medical practitioners, clinicians, researchers, and others to exchange ideas on approaches to setting and supporting CAM research."

MS. SCOTT: I just thought you read it differently than what it said.

DR. ORNISH: I did? Julia, talk into the microphone.

MS. SCOTT: Did you end with "research"?

DR. ORNISH: I thought I did.

MS. SCOTT: Mine ends with "questions."

DR. ORNISH: What is the date of yours?

MS. SCOTT: Oh, I have no idea. It was in the book.

DR. JONAS: You are looking at the text. It is not exactly the same.

DR. ORNISH: Oh, how about that. So, what is

the more current one? 11-16. They both say 11-16 on them.

MS. SCOTT: I was on page 5. Recommendation No. 4.

DR. ORNISH: Number 4 is different from the one that is in the summary at the beginning. If you look under Tab 7, page 5, there are recommendations there, but if you look in the very front of the book, under Tab 1, it has the summary of all the recommendations throughout the binder.

MS. SCOTT: Is that what you are on?

DR. ORNISH: I was using the one in the front just because they are all in one place, but I didn't realize there was any discrepancy.

MS. SCOTT: Okay. They are not the same.

DR. ORNISH: So, what is the more current version? They both have the same date on them.

MS. SCOTT: I think you just have to decide which one you are going to use. We will just all go to the one in the front.

DR. GORDON: Which one did you work off of?

DR. ORNISH: Well, the one I was working off

today, I have been looking at the summary at the beginning. I presumed they were the same since the dates are the same.

DR. GORDON: I would like to suggest whichever one you and Wayne have been working with most consistently. Have you been working with the same one?

DR. ORNISH: Gerri is saying we should use the ones under Tab 7 because those were probably brought forward to the summary.

So, No. 4, "The Commission recommends independent or collaborative support by the public, private, and nonprofit sectors for organizing multidisciplinary conferences on CAM research and related activities to increase opportunities for CAM and conventional medical practitioners, clinicians, researchers, and others to exchange ideas on program policy and research planning and methodological approaches to setting CAM questions."

I think there is an overarching issue. We shouldn't have any sentences that require you to take three breaths when you read them.

DR. JONAS: Let's truncate it at "related

activities." "Multidisciplinary conferences on CAM research and related activities."

DR. GORDON: Fine.

DR. ORNISH: Good. Do we want to say "on CAM research that has been shown to be safe and effective," or --

DR. GORDON: No, because the research can show it is not safe and effective, too, that is good research, as well.

DR. JONAS: The point of this is that we think there should be more multidisciplinary conferences on CAM research and related activities.

DR. ORNISH: Good. Perfect.

DR. JONAS: How about "and research methodology," we add in here? "And research methodology"?

DR. ORNISH: Well, if you start talking about, again, research methodology, then, you are getting specific, and then you say, well, why not be specific about other areas of research.

DR. JONAS: That is a large overarching issue.

DR. GORDON: To me, "research" covers --

DR. ORNISH: Research methodology, certainly is a subset of research, but so are lots of other issues.

DR. JONAS: Actually, not, very infrequently do they really focus on research methodology. They are usually focusing on a particular topic they are researching.

DR. ORNISH: Okay. I don't have strong feelings about it, if it is important to you, let's include it. Is everybody okay with that?

DR. GORDON: Which are we going to do?

DR. ORNISH: It is going to say: "The Commission recommends independent or collaborative support by the public, private, and nonprofit sectors for organizing multidisciplinary conferences on CAM research, research methodology, and related activities."

DR. GORDON: Is that okay with everyone?

DR. ORNISH: All in favor?

[No response.]

DR. GORDON: Okay.

DR. ORNISH: Number 5. "The Commission encourages the creation of novel funding partnerships or consortia within the nonprofit sector and the private

sector to augment collaboratively with federal agencies or separately support for CAM research, research infrastructure, and training, research conferences, and information dissemination."

DR. FINS: I thought it was kind of vague, "novel," you know, I didn't know what that meant. I know what we mean, but I didn't like the word "novel."

DR. ORNISH: How about "innovative"?

DR. FINS: Better, but --

DR. ORNISH: How about just funding, "creation of funding"?

DR. FINS: Yes.

DR. ORNISH: Take out "novel."

"The Commission encourages the creation of funding partnerships or consortia within the nonprofit sector and the private sector" -- we could just make it simple and just say, "to augment support for CAM research, research infrastructure, and training," and then leave out the part about "collaboratively with federal agencies or separately," or at least put that at the end of the sentence, so it doesn't sound like such a long run-on sentence.

DR. PIZZORNO: In the interest of brevity, et cetera, do we need this? It seems self-evident. Does this commission have to actually say this?

DR. ORNISH: We don't have to say anything, but we are trying to use a bully pulpit to encourage people to do these things. I think as anyone who has ever tried to raise money to do research, I would say, yes, that is a pretty good one to have in there, but I think we can shorten it.

DR. JONAS: Also, as you recall, there were many more recommendations in this one section even before this, and we went through and said, well, which ones do we want to highlight, and this was one we felt like was important to highlight, is that there should be more activity in which there is kind of joint and collaborative funding mechanisms.

DR. ORNISH: So, how do you want to shorten it?

DR. JONAS: I don't want to shorten it. I like it like it is.

DR. ORNISH: Like it is.

Okay. All in favor? All opposed?

DR. FAIR: May I make one comment?

DR. ORNISH: Sure.

DR. FAIR: I like it, short or long, because the business about the private sector. I just spent this weekend at a meeting in Palm Beach, a workshop and conference on Cox-2's and specific inhibition in cancer treatment and prevention, and it is really an exciting area.

It turns out Cox-2 is induced in the neovascularity of tumor vessels, so that Cox-2 inhibition is a strategy which is really virtually nontoxic for the inhibition of tumor growth.

The interesting thing to this meeting is that if one looks back -- and many of you know more about herbs than I do -- but in the ancient traditional Chinese medicine, and also in Hindu medicine, things like curcumin and turmeric play a major role in the multiple prescriptions for preventing cancer.

It turns out that coumarin and curcumin have high levels of Cox-2 inhibition. Of course, up until 10 years ago, we didn't know what Cox-2 was, so people would say, oh, well, there is no evidence that those herbs work.

So, I think that something like this would make an ideal collaboration between an industrial firm, which this happened to be Pharmacia, and complementary medicine to explore some of these interactions between the two, and I think it is another area where we could link the ancient healing arts with modern and molecular biology.

DR. ORNISH: Thank you. That is very good.

DR. FAIR: I would like to see something in there about the private sector.

DR. ORNISH: It's in there. You mean you like what is in there, you are not suggesting we revise it?

DR. FAIR: No, I just thought, I don't whether it is possible to put industrial pharmaceutical industry or something like that in there.

DR. ORNISH: Well, that is included in the private sector. Do you want to make it more explicit? We could say in the private sector (including the pharma and industrial), but that is going to make it even longer. We could put something in the text on it, Gerri, so we can clarify it that way.

But just to digress, I like what you are saying, and I think that so often we can do studies

showing that there is an effect before we understand the mechanisms by which that effect is occurring.

Certainly, in our studies 25 years ago, when we found heart disease is reversible, people don't know about, you know, endothelial function and vasomotor tongue changes, prostacyclins, and all the different mechanisms and inflammation that we now understand.

So, thank you for bringing that up.

Can we move on? Other comments?

MS. POLLEN: Just read that quickly.

DR. ORNISH: "The Commission encourages the creation of novel funding partnerships or consortia" --

DR. JONAS: We struck "novel."

DR. ORNISH: I'm sorry, thank you.

It is basically the same, what is in there.

MS. POLLEN: Are we taking out "collaboratively with federal agencies" --

DR. ORNISH: We thought about putting that at the end of the sentence, but we can leave it where it is, or do you want to take it out?

DR. JONAS: No, I think the point is exactly that.

DR. ORNISH: So, you can either leave it there or move it to the end of the sentence, whichever looks better.

A friend of mine has three kids, and the whole family talks incessantly, and they have this thing embroidered on their pillow that says, "Lose your breath, lose your turn." So, I want to make sure that I keep going here.

No. 6. "The Commission recommends supporting research on why people use CAM, how they determine its effectiveness, and what they find satisfying about CAM itself and in comparison with conventional medicine, and parallel this research with the public impact on the emerging integrated health care system."

My recommendation is to delete this one, but I am open to any suggestions anyone has.

DR. JONAS: I would like to suggest we reword it. Do you have a wording?

DR. FINS: Recommend supporting health services research on the demographics of CAM utilization and outcomes, just basically, there is a whole other kind of research as health services research.

DR. JONAS: That is actually not how I was going to suggest rewording it. We do have health services research later. This is not exactly that. This is actually sociological research looking at reasons for CAM use.

DR. FINS: You could say sociological use.

SISTER KERR: But it includes anthropological, too, so you have got to keep it broader.

DR. JONAS: And anthropological, yes. I think we ought to use lay terms in this area, I mean, to get at the same thing.

DR. FINS: Social science.

DR. JONAS: Social science research. I think that would be okay, "supporting social science research."

DR. FINS: Exploring why people use CAM, et cetera.

DR. JONAS: Exploring why people use CAM.

SISTER KERR: Wayne, my opinion is if you say more than just why, you are predicting what the reasons are. It could be cosmic, who knows. That is not sociological or anthropological. We don't know why.

DR. FINS: If you just simply say "sociological

research exploring CAM utilization," period, that would capture it, and then each of the investigators would come up with their study design.

DR. JONAS: I think "why" is a very important word in this recommendation, because it focuses on really trying to work with patients and the public to say, you know, what is it do you want. Now, that is what sociological and anthropological in qualitative research does, but I think if you say those and you leave out why, people won't know that.

I would like to truncate it, however, and we could say, "supporting sociological research on why people use CAM, how they determine its effectiveness" -- which I think is very important -- "and what they find satisfying and unsatisfying about CAM" -- period. That would end the sentence.

DR. FINS: Or their degree of satisfaction.

DR. JONAS: Or their degree of satisfaction. It is different, though. I mean, the degree of satisfaction and what it is that produces the satisfaction are different or unsatisfaction.

DR. ORNISH: I like the fact that you are

putting satisfying and unsatisfying, because it sets a tone that we are not advocates of CAM, that we are trying to find out what is true.

DR. JONAS: And then a period after "CAM."

DR. ORNISH: But I would take out the word "sociological" because why limit it, because there are many forms of research, not just that.

So, you could just say basically, "The Commission recommends supporting research on why people use CAM, how they determine its effectiveness, and what they find satisfying and unsatisfying about CAM" -- period. Is that okay? Tom.

MR. CHAPPELL: I agree. When you begin to qualify it, it just starts sending it in different directions of research.

DR. ORNISH: Anything else?

[No response.]

DR. ORNISH: Number 7. "The Commission recommends that federal agencies supporting biomedical and health services research develop training programs for public representatives to help them provide input to the agencies in the most effective way with respect to

biomedical and health services research agendas and budget policy and the dissemination of information."

Definitely shorten that one.

DR. GORDON: I am not sure what the connection is here with CAM, and I think that has to be made explicit why this has anything to do with CAM.

DR. JONAS: I thought we dealt with this later on. I thought we had a specific recommendation later on when we talked about public input that dealt with this. That doesn't really clearly capture that.

This got back to, Julia, what you were mentioning, and we had talked about before, about simply having people sitting on boards as public representatives is inadequate, that we need to develop ways in which they are particularly trained to do that properly.

So, this recommendation is saying this needs to be done in research also.

DR. LOW DOG: Maybe we could just be more specific. You could say, "public representatives that are sitting on boards that have to do with complementary and alternative medicine research," but then you could also say, comma, "and conventional," I mean, for both,

but it does leave you wondering, and I think it needs to be shortened. I think we need to shorten it.

DR. JONAS: I think we could cut out the last part of it where we don't have to necessarily list all the different things they would sit on.

DR. GORDON: The other question I would raise about this, Wayne, is that there may be people who are CAM professionals sitting on these boards, who also don't understand research. You can see this is as part of the effort to provide kind of conventional research training for CAM practitioners and others who may be involved in this process.

DR. JONAS: Okay. You could utilize it for that, right. I would hesitate to insert that in here and then isolate CAM practitioners as opposed to other practitioners who also don't know how to do research.

DR. ORNISH: What if we just put a period after the "in the most effective way" -- period. Can we all agree on that?

DR. GORDON: After what, Dean? I'm sorry.

DR. ORNISH: In the sentence, "to provide input to the agencies in the most effective way" -- period, and

delete everything that follows. I mean, not for the whole book, but just for that paragraph.

DR. GORDON: Somehow this has to relate to CAM. The word isn't even in the recommendation.

MR. CHAPPELL: What is the result of this? Are we training the power brokers or what?

DR. JONAS: No, we are training the unpower brokers.

MR. CHAPPELL: Who are lucky enough to get into the power systems.

DR. JONAS: Right, empowering public and consumer representatives to be more effective in terms of guiding research in these areas.

DR. ORNISH: So, why don't we just say, "The Commission recommends that federal agencies supporting biomedical and health services research in CAM develop training programs for public representatives" -- blah, blah, blah -- "in the most effective way."

"In CAM and conventional health care"?

Can we all live with that?

It would say, "The Commission recommends that federal agencies supporting biomedical and health

services research in CAM and conventional health care develop training programs" -- blah, blah, blah -- "in the most effective way."

DR. JONAS: I would way, "to ensure more effective input."

DR. CHOW: It goes back to the other issue that we took up earlier, to have informed and empowered representatives from the public.

DR. JONAS: I like that. I would like to use those words in there.

DR. CHOW: To inform and empower the representatives.

DR. JONAS: I would like to use those words in here because it is not simply training. I mean, what you really want is you want a program that empowers and informs, informs and empowers, so that they can better participate, and part of that would be training, but there also may be other methods.

DR. ORNISH: So, how about if we say, "The Commission recommends that federal agencies supporting biomedical and health services research in CAM and conventional health care develop training programs to

help empower and inform public representatives" -- oh, I see -- "inform public representatives, to help empower and inform them to provide input" -- blah, blah, blah.

DR. JONAS: That's fine. It is in our Guiding Principles.

DR. ORNISH: So, we have got that. You can work out the details on that.

DR. JONAS: We will reword that, but try to include the empowerment and training issues.

Before we go on to the next recommendations, are there any comments on the text part that goes with each recommendation?

[No response.]

DR. ORNISH: If not, moving on to Recommendation No. 8.

DR. JONAS: Just a minute. I have several comments, but I wanted to give the Commission actually the opportunity to make a comment.

DR. GORDON: Are you going to make comments about the previous text?

DR. JONAS: About the text that just preceded these four recommendations.

DR. GORDON: Go ahead.

DR. JONAS: In applying the same standards, under No. 1, I think I like this as is written. I would like to add -- page 2, line 9 -- I think we ought to add also that the Commission recognizes that the interaction of orthodox and unorthodox research may help in evolving new and innovative research methods.

It has been demonstrated historically that by having this creative tension between those that are outside the mainstream and inside the mainstream, that new methodologies, not simply the same standard methodologies are evolved.

So, it is a statement about evolving methodologies, that research methodologies are not static, that just because we think they should be the same, it doesn't mean it should always be the same.

DR. ORNISH: I want to comment on that because I think that is an important point, but I wouldn't put it here, because the thing that I am trying to avoid is the land mine of having people say, well, CAM has its own methodologies that are really different than conventional methodologies, and that leaves it open to the fact that

they are not as rigorous.

My preference would be to put it under some other place where we talk about research methodologies, which I think is further along here, because I think it's an important point, I just wouldn't put it there.

DR. JONAS: I am not sure I like that. This actually brings me back to a concern I have about the word "same," because what I am really interested in is high standards.

If the standards in conventional medicine are low, and there are some areas where they are very low, I don't think we should necessarily apply the same standards.

DR. ORNISH: But, Wayne, it makes it pretty clear in this paragraph. I love this paragraph myself, because what it says is that, you know, that, on the one hand, people think that CAM is held to a higher standard, on the other hand, the conventional journals often say CAM research doesn't even come to the same standards, and here we are saying it should be a level playing field, they should be the same standards of high standards of excellence applying to both.

I think that is really important.

DR. JONAS: We are saying applying high quality standards there.

DR. ORNISH: Well, it says, "meet the same high standards."

DR. JONAS: It doesn't say meet the same standards.

DR. ORNISH: No, it says, "Meet the same high standards of quality and rigor."

DR. GORDON: Isn't the wording, "same high standards"?

MS. POLLEN: Yes, it is.

DR. JONAS: I would put that up in the title then also.

DR. ORNISH: That's okay.

DR. JONAS: Well, whatever. I mean, I think the thing about evolving, how methodology is evolving, and that research in -- that is one of the contributions of doing research in complementary medicine is that it can help you evolve your standards properly.

DR. LOW DOG: Is that what we were trying to get at on page 9, when you get to 18, we were talking

about the methodology?

DR. ORNISH: Exactly, precisely, that is exactly where it is.

DR. LOW DOG: And then we moved down and we talked about the controlled trial is the gold standard, but then we went into the complexity.

DR. ORNISH: Exactly.

DR. LOW DOG: Did that not cover it?

DR. JONAS: Page 10, you mean?

DR. ORNISH: Page 9 and 10.

DR. LOW DOG: Yes, 9 and 10. It starts on like No. 18 and then moves down, but I thought that is what we were trying to get at.

DR. ORNISH: It was.

Joe.

DR. FINS: In this umbrella section, and maybe also going back into Recommendation No. 2, we should say something about -- you know, we talk about standards, but I think it is important to say, you know, the ethical standards, the conduct of research.

We do get to it later, but in a more sort of particularistic way, but I think it is an over-reaching

concern.

DR. ORNISH: I don't object to putting this in the paragraph on page 2, "the same high standards of quality, rigor, and ethics."

DR. FINS: Right.

DR. ORNISH: I don't think that is a problem. I think it just makes it sound even that much better.

On page 2, No. 9, line 9, just add, "meet the same high standards of quality, rigor, and ethics."

Tieraona.

DR. LOW DOG: I guess my question was just, Wayne, was there something more you were looking for?

DR. JONAS: Yes, actually, this does not address it, however, I do think this is a place it could be addressed. We could put it down there.

DR. ORNISH: Perfect. Okay. What other issues do you have?

DR. JONAS: I am not sure what the relevance of the first paragraph under Public Use and Input is. It seems like a recitation of what we had in the beginning. It doesn't deal with research.

DR. ORNISH: I agree with you.

DR. GORDON: We have a lot more recommendations to go through, so I just want to urge us to -- if everyone agrees that this issue should be dealt with, then, I think we can leave it to the text writers to deal with it either on page 9 or page 2, or page 3.

DR. ORNISH: I think you are right, Jim, Wayne, if you are comfortable, let's go through all the recommendations, see if we can get consensus, and if there is any time left over, we can go back to the text and fix that.

DR. JONAS: I don't want to do that. I want to deal with the text under each recommendation, so that we at least have it in our mind what the recommendation is, but I am finished with any of my comments about this first section.

DR. ORNISH: Okay.

MS. POLLEN: Wayne said he had a problem with the first part of the second paragraph on page 2, but we could start with "the growing influence" and delete everything above that, if you wanted to.

DR. ORNISH: That sounds good.

DR. JONAS: I think this paragraph, since it is