is that we need to get more specific. I think we need to find the right place to get specific, and then not get specific every place, because if we do, it will be boring and overwhelming.

Does that make sense, Dean?

DR. ORNISH: I agree with you, Tom, that we could flesh out in the text more of the evidence. My work, for example, is a good example of this, and it is not in there. I mean, we could lots of things that we could be citing that we haven't done in the text.

So, I agree with you completely that have more substance and impact and specifics in the text, and I actually share your belief, but I do think that there is some benefit in keeping the recommendations concise because once you start to get specific about one thing, it raises the question why did you pick that one, and leave out all the other ones. It also just makes it long and unwieldy as we have seen before.

DR. FAIR: But you can be concise in one sentence. Your 10 leading health indicators here, if they are given in order, are physical activity or lack of, and overweight and obesity. I mean, I can't believe

that environmental quality ranks anywhere near those two in terms of health care indicators.

With all due respect to Dean, you know, it is one thing to put a man through your excellent program at age 50, but we are talking about kids that are 10 years ago have a much longer time to go, and the best time to indoctrinate them into a healthy lifestyle is when they are young.

DR. ORNISH: Do you think I disagree with that?

DR. FAIR: Can you disagree with it?

DR. ORNISH: No, I said do you think that I would disagree with that?

DR. FAIR: I would hope not.

DR. ORNISH: Well, I don't, so I am not sure what the point is.

DR. FAIR: The point is that you have another 40 or 50 years when you approach children as opposed --

DR. ORNISH: We are coming to the issue, Bill, just hang on just for a minute, we are almost there. We are talking about Recommendation 1, the children comes in Recommendation 3 and 4, and I hope we will get to that, I thought we would already be there actually, so I

understand your impatience because I am a little impatient myself.

Tom?

MR. CHAPPELL: The issue that we are talking about is the utilization of CAM to help achieve nation's health promotion and disease prevention goals.

I think my concern was really lifted out a little bit more specifically by Jim's comment that there are going to be areas -- this is an opportunity section to be specific about our goals, about health promotion goals.

I would hope somewhere in a recommendation we actually have those more specifically.

DR. ORNISH: Tieraona.

DR. LOW DOG: I would like to make -- we don't really have it under Research, and it may appropriately go there, but perhaps part of what is needed is also research into more of these. When we are talking about obesity, I think there is an assumption that with CAM, you can help people to lose weight and actually there is no really good evidence that that is the case.

Many people are chasing a lot of products to

lose weight, some with deleterious effects, but I think there needs to be more exploration of the research to see what the outcomes actually are for more of these CAM modalities and practice to see actually do they prevent illness, to what extent, and at what cost, and how much do they actually promote health or change behaviors because I hear what you are saying, Jim, but behaviors are very difficult to change and systems, and, you know, that is why tobacco cessation, the things that really changed it was banning them in public places and increasing the cost of cigarettes, but I mean, those were systems changes.

Safety belts, nobody wore them just because they thought it was going to prevent them from getting in a car accident, it was because you got fined if you didn't wear your seat belt, so I mean, a lot of public health and preventive strategies have been through public policy and through systems changes, and I think at this point some of these CAM practices and principles that we think may be beneficial for that, it is premature to say that they are actually going to change behavior, they are going to prevent illness, or they are going to promote

health.

I think that some of this data is available, but not to the extent that it comes through in this document.

DR. ORNISH: I want to distinguish between the recommendations and the text. The recommendations talk about safe and effective CAM, so that to me covers what you are saying. I do think that we could expand the text more to include both the need for more research, the evidence of things that do work, and equally important, the evidence of things that don't work or the importance, at the very least, of using research to help sort out what works, what doesn't work, for whom, and under what circumstances. I completely agree with that, and I think that could be more beefed up -- it is probably the wrong term.

DR. GORDON: Tieraona, I would say that there are certain fundamental approaches for which there is a fair amount of evidence for many of these conditions and for psychological conditions, as well, physical exercise, dietary change, and stress management.

DR. LOW DOG: I don't consider physical

exercise as CAM.

DR. GORDON: I understand, but for our purposes, at this point, it is CAM, as well as conventional. It is one of those overlapping circles. It is not CAM. For example, we don't need to go into this at great length, but, for example, not much is taught in conventional medical education about using physical exercise therapeutically.

DR. LOW DOG: How much is taught in massage school, acupuncture school, I mean, how much really in exercise?

DR. GORDON: Listen to what I am saying. It is not -- that is one of the problems of those schools, as well.

DR. LOW DOG: [Off mike.]

DR. GORDON: Let me just continue. I am trying to make the case for what we are doing. I am not saying that there aren't gaps in all of these educational programs. I think Chinese medicine programs that don't teach qigong and Tai Chi are ridiculous. That should be part of the curriculum, working with those techniques of movement.

But the point is these are approaches that are part of CAM approaches, whether or not they are also part of conventional, which is they are not emphasized. We have done surveys of what is taught in nutrition in most medical schools, and as you know, it is not very much.

DR. ORNISH: Okay. Let's move on.

DR. GORDON: Stress management, not very much. Those are aspects of CAM for which there is good evidence they are safe, they are effective, they can have a significant effect on a variety of different conditions.

I think we ought to enumerate those.

DR. ORNISH: I need to point out, Jim, that we are still on the first point here, and we have been doing this for 25 minutes, so I would like to move on. I didn't really think that No 1 was going to be this controversial frankly, but I do think that No. 1 covers everything that has been said as long as we expand in the text all of the other things that have been very helpfully pointed out.

Can we all live with that?

MS. AXELROD: Can I just add that in previous meetings, we have asked for people to send in any

examples of information, and some of you have done that, it has been very helpful, so I just want to make a plug again, if you have examples that you think would be helpful, please send them to me ASAP.

DR. FAIR: On the conference call, I thought there was total unanimity that we would make this discussion, I mean, we would recommend education in the schools starting early.

DR. ORNISH: We are almost there, Bill, we are almost there. That is the third point. We are still on the first point.

Charlotte.

SISTER KERR: I just want to comment on what I am observing. There is a lot of passion by some people that something is not just quite right, and rather than maybe -- at least this is how I feel about it, maybe everyone else doesn't -- rather than resisting that, I am wondering what is that, what is so important that is not here, that we need a listening for, so we get it right, so we meet our mandate.

I just wanted us to kind of take a minute to think about is there something that is it so important

that these people are so passionate about that we haven't gotten, and we want to do that.

DR. ORNISH: I want to clarify. I appreciate what you are trying to say, that it is just a question of where you put it, it is not a question of whether it is included, and I completely agree the points that everyone has made should be included in here, but I think they should be included in the text because if you start making the recommendations three or four paragraphs, it doesn't work, and I thought that was something that we had all agreed to in our previous discussions, and so it puzzles me why suddenly we are changing that now.

I think that everything that has been said has been incredibly useful and constructive and helpful, and will be included in the text, but I do think that all of those things are subsumed in the recommendation as it currently exists, and when we start to make it more broad or specific than that in the recommendation, it becomes unwieldy.

I am open to sort of reconsidering that and to changing it in whatever ways you all want to, but that is where I am coming from.

MR. CHAPPELL: Dean, I appreciate your patience with me on this. I think the recommendation responds to a world view without helping to present our world view, and the opportunity that I see missed in this section, both in the text and in the recommendation, is that we don't have the promotion here of a list of CAM modalities that can, in fact, contribute to the nation's health promotion and disease prevention.

DR. ORNISH: Tom, I just want to interrupt you in the interests of time. All we are talking about is where you put it, okay. I agree with you that those should be broadened and expanded upon in the text.

The only place I think that we might disagree is how much of that should go in the recommendation itself.

MR. CHAPPELL: Then, I would like to see it more coherent in the text as something that is as euphemistic as the 10 leading health indicators juxtaposed with the 10 leading CAM modalities to deal with that. The opportunity is not being fulfilled here of our world view.

DR. ORNISH: I am not aware that you can

actually come up with a CAM modality to match it for each of these indicators.

MR. CHAPPELL: I am not sure we can, but I am sure that this is not enough as a way to promote our point of view of health promotion and disease prevention.

DR. ORNISH: I am going to just end this discussion now by saying I would welcome any comments that you or anyone else has in how we can broaden the text. Since several people have seemed to feel very passionately about this, it would be really helpful to channel some of that passion into actually giving us the text, giving us the specific examples that you would like to have included in the text, and we will do that. That would be very helpful.

DR. GORDON: There are issues that people want changes in the language in the recommendations.

DR. ORNISH: Well, if you have any suggested change in the language of the recommendations, we would certainly -- I mean, if you have them now or if you have them later, we would welcome them.

Does anyone have any specific changes in the recommendation language that they would like to see other

than just listing CAM modalities in there?

DR. FAIR: I will send you one because I don't see it in the text either, Dean, and we are missing a golden opportunity. Rumor has it that Ted Cooper is going to be the next Surgeon General, and if that is the case, we would have support there. I think it is a golden opportunity for this committee to take a strong stance.

DR. ORNISH: Specifically, Bill, what would you like it to say in that first recommendation?

DR. FAIR: I would like to say that education relative to proper nutrition and exercise should be incorporated in the school programs from K through 12, and I think there are enough data. I mean, I wouldn't argue with you on these things, but I think there are some data --

DR. GORDON: I would say stress management, too. I have that, too. I have that in there as very strong language.

DR. FAIR: There are data that those things work.

DR. ORNISH: Again, we are talking --

DR. GORDON: We are talking number.

DR. ORNISH: Let's talk about Recommendation No. 3, because I am a little frustrated here, because I keep saying that we are about to get to it, and I am not feeling like I am being heard.

DR. GORDON: I think, Dean, the issue is that you are not feeling like you are being heard, and they are not feeling like they are being heard, and I think it's wise to go to No. 3. I think once we get this language down in one place, the other recommendations will go easier.

DR. ORNISH: Let's talk about Recommendation No. 3. Bill.

DR. FAIR: I have this question about where appropriate, what is it appropriate, where is it not appropriate.

DR. GORDON: Bill, why don't you just make the language that you would like to have and just start with a clean slate on No. 3, what language would you like there and let's see how everybody feels about it.

DR. FAIR: Well, words to the effect that we would strongly recommend that proper dietary habits and

exercise should be incorporated in the school program starting at Grade K through 12.

DR. ORNISH: I think that is a really important distinction to make when we can say things like diet, exercise, and maybe even stress management. When we talk about CAM in general, it raises a lot of fears particularly in the right wing and the different ends of the different ends of the political spectrum that you are going to be teaching my kid, you are going to be forcing my kid to be chanting in Sanskrit in public school and the devil is going to take over their brain while they are doing that.

I mean, I actually hear this a lot even from the people that we teach meditation to as adults, so people get very sensitized to what they feel like -- if you stay with diet and nutrition and exercise and maybe stress management as opposed to CAM in general, I completely agree with you.

DR. GORDON: Why don't we say that, if we agreed on that, let's make that the recommendation.

DR. FAIR: I was just thinking of even diet and exercise, I agree with you about the chanting and

Sanskrit and stuff, that is a land mine, but certainly it is hard to imagine that diet and exercise would get anybody too upset.

DR. GORDON: I would say diet, exercise, and stress management, and I think stress management is accepted, chanting and Sanskrit has a mixed review.

DR. ORNISH: You can use stress management, but if you use the word "meditation," then you are hitting a land mine. If we could all agree that the Commission strongly agrees that diet, stress management, and exercise should be part of education K through 12, and an important part of the education K through 12, and in the text we can make reference to the fact that physical education programs are being cut back now, which I think is ridiculous at a time when childhood obesity is epidemic and childhood diabetes is epidemic, so I think we are all in agreement about that.

DR. GORDON: Can we have that as a recommendation and a consensus>? Joe.

DR. PIZZORNO: It is not clear how you are doing that. Could I suggest on the second line it say, "Where appropriate, CAM practices such as diet, exercise,

stress relaxation" comma ,--

DR. ORNISH: I think if you do that, you are really opening the door to some real resistance. Instead of saying, "Where appropriate, CAM practices such as," I would just say, "Diet, exercise, stress management" -- blah-blah.

I just want to point out the land mine when you say "for example," then you are saying you are including this and other CAM modalities, then, it is a very small stretch from there for a critic to say, oh, you know, the recommendation is that --

DR. GORDON: Let me think of one way to accommodate this, if we make a very clear statement, "Diet, exercise, and stress management should be included in all school programs K through 12," and then we can make a later recommendation in the area of wellness or maybe it comes under research, "research needs to be done on the appropriate use of a variety of CAM therapies to promote wellness," something like that.

DR. ORNISH: That's good.

DR. GORDON: Bill, are you with me on this, are you beginning to understand?

DR. FAIR: Thank you. I mean, I don't view anything esoteric. I think diet and exercise, and if you want to add stress reduction, that is fine.

DR. ORNISH: Does that fully address your concern?

DR. FAIR: Yes.

DR. GORDON: I agree with you. I think it is going to be a very important item for us to talk with Ted Cooper and to talk with Congress about.

DR. ORNISH: Ken Cooper.

DR. WARREN: Are you planning on eliminating the last sentence about the media campaign? Are you going to keep the media campaign in it?

DR. ORNISH: Yes, I think that's good.

Now, can we go back to Recommendation No. 2, which we skipped? "The Commission recommends that questions on specific CAM uses be included in the national surveys that are the sources of the HP-2010 data including the National Health Interview Survey" -- blah, blah, blah.

I mean, you are right, these are kind of boring, but they are important.

DR. PIZZORNO: I would like to see one minor change, and that is, after CAM, put "provider and practice usage," so we are looking at CAM provider usage, not just CAM practice usage.

DR. JONAS: I just want to mention that not only is it boring, it is already ongoing. They are already included, these questions are already included in the National Health Interview Survey.

DR. ORNISH: So, do you want to just eliminate it? All of these surveys are? Some of them are, I don't think they all are.

DR. JONAS: The major ones, the ones that are ongoing data collection nationally that are run by CDC and National Center for Health Statistics are.

DR. ORNISH: Wayne, are you recommending that we delete the Recommendation No. 2 as being redundant?

DR. JONAS: National Health Interview Survey, National Health Nutrition Examine Survey, I am not sure about that one, but the first and the third one, they are in.

DR. ORNISH: So, what is your recommendation?

DR. JONAS: I would suggest that rather than

just say we ought to collect data about this in these surveys, is that what we should do is that we should incorporate CAM practices that have been proven to be safe and effective into recommendations for how to implement Healthy People 2020.

DR. ORNISH: That sounds good.

SISTER KERR: Just a point of clarification. Is there actually a Healthy People 2020 already in process?

DR. ORNISH: I don't know.

SISTER KERR: The people from Candace or the lady -- that report that was sent to us, they talk about 2020 report.

DR. ORNISH: According to Corinne, there is.

MS. AXELROD: The Healthy People, actually there is an ongoing process, and it is a very organized process. They have working groups, consortia, so it is an ongoing thing, and they are working on HP-2020.

DR. JONAS: Yes, and that is the exact opportunity then that we have to make recommendations that complementary and alternative medicine discussion or representation or however you want to phrase it, be

included in that process.

DR. ORNISH: Okay. Now, Bill, how strongly do you feel about Issue No. 3, should we go back to the way things were originally and have Issue No. 2 first, which would then make Recommendation No. 3 first? The thinking was that -- Recommendation No. 2, we did.

Is everyone familiar with Wayne's recommendation?

DR. WARREN: What is it?

DR. ORNISH: Wayne, do you want to say it again?

DR. JONAS: The Commission recommends that there be input on the role of complementary and alternative medicine in achieving health goals of Healthy People 2020. I will have to think about a smoother way of writing that, but essentially, that is the recommendation.

MS. AXELROD: I am still not clear, though, if you all want to delete the data collection part, I am not as convinced that all this data is actually being collected, but even if it is, I don't think it does us any harm to advocate that that data is included, and

there may be other surveys, as well, that we might want to add.

DR. ORNISH: I would include that plus expand to what Wayne is advocating. Can we all live with that?

DR. GORDON: How is it going to read now, please?

MS. AXELROD: We will keep the first part about the data collection and then we will incorporate the data from these surveys into achieving the goals of HP-2020 or something to that effect.

DR. GROFT: I think what we will do, too, we will find out exactly what surveys are ongoing and especially NCCAM, I think would probably be the primary group that would provide some support to do the study or to put questions in. Usually, that is the way you get questions in, several hundred thousand to do it, so we will check into that.

DR. PIZZORNO: One of the needs we have is data on CAM providers. Are any of these doing things like measuring the number of naturopathic doctors, acupuncturists, chiropractors, massage therapists in the country. I mean, there is no exact numbers for these

things.

Are those part of these kinds of surveys being done?

DR. ORNISH: I would defer to Wayne on that.

Do you know, Wayne?

DR. JONAS: Most of these that I have seen in these ongoing national surveys have not addressed issues of the Cam practitioners of CAM use, following kind of the David Eisenberg survey, although many of them have included have you visited non-conventional practitioners, some of them then leave the question open like that, and some of them give some examples, but very few of them give a complete list.

MS. AXELROD: I have some information on that. Actually I have given this to Joe who sent it out to the Education and Training workgroup, but I guess that group decided not to act on it, and perhaps has something that can go on Access, but there are several things like the resource file, the U.S. Health Work Force Personnel Fact Book.

I have a list of about eight different major data collection of practitioner types of information,

everything from the census to stuff in HCFA, stuff in the National Center for Education Statistics, so I think many of you already have copies of this, but it might be more appropriate to have that in Access since it doesn't just apply to Wellness.

DR. ORNISH: So, getting back to the question of whether we should move the Issue 2 section back to where it was, as Issue 1, Bill would you be more comfortable if we do that? In that way, Recommendation 3 will become recommendation No. 1

DR. FAIR: What happened to the K through 12? That is eliminated?

DR. ORNISH: No. We are talking about Recommendation No 3.

DR. GORDON: Bill, what Dean is saying is that the recommendation about K through 12 would become the first recommendation in the section.

DR. ORNISH: In the last draft of this, Issue 2 was where Issue 1 is, and vice versa. Issue 1 is now where it is because it's the more general idea, and then the others have become subsets, but it doesn't have to be that way.

Since you feel as strongly as you do about Recommendation No. 3, if we move Issue No. 2 to Issue No. 1, that will make it the first recommendation. Does that make sense?

DR. FAIR: I guess I don't understand it. I thought that our best chance to make a really strong recommendation is that one about, not CAM, but diet and exercise, and maybe stress reduction is No. 1.

DR. ORNISH: Let's just switch these. Let's just switch the positions of Issue 1.

DR. ORNISH: Corinne, can you read Recommendation No. 3 as it stands, just we are all perfectly clear/

The Commission recommends that CAM become part of a national focus to improve the health behaviors of children. Where appropriate, diet, exercise, and stress management should be incorporated into educational programs from Kindergarten to 12th grade is all school programs as part of the National Guidelines on Wellness and Prevention Practice for Children, and a media campaign be conducted that includes public service and involvement of public figures to teach and encourage

Health Behaviors among children.

DR. GORDON: I would just say that I think we struck out the "where appropriate."

DR. ORNISH: You might just make a second sentence, also a media campaign shall be conducted just so it is not such a long sentence.

DR. FAIR: I won't beat a tired horse, but why can't we just make the one recommendation K to 12, with diet and exercise and stress reduction. I mean, if you did something like that, that would be picked up by somebody like Jane Brody or something, and one of these give national attention to it.

I think if it's lost, then a three-sentence recommendation, never likely to miss that opportunity, but that is a personal opinion.

DR. ORNISH: We can delete the first sentence and just go into the second sentence, which will make it now the first sentence,

SISTER KERR: I kind of agree with that. I think we need to think that all the way through with these run-on sentences. In this case, this could be three short sentences.

DR. ORNISH: Why don't we just make it, I mean, we can delete the first sentence, and how would it start then?

DR. GORDON: I think the first sentence is important in tying these things in.

DR. ORNISH: Well we will have three sentences. We will have the first sentence, we will have the second sentence, about K through 12, and we will have the third sentence about media.

Can we all live with that?

SISTER KERR: The last thing I want to say about it is are we, as a group, clear that the only three things we want to say are diet, exercises and stress management.

DR. ORNISH: And energy medicine, too.

SISTER KERR: How about low fat?

DR. ORNISH: No. 4. Do you want to read it?

DR. GORDON: Do you want to read it, or do you want it ready for comments?

DR. ORNISH: Why don't you give us your comments?

DR. GORDON: I think it has to be stronger, and

I would day, "The Commission recommends that, in partnership with the business community and school boards, that schools develop healthier school lunches and snacks, and eliminate the sale and advertising of high fat snacks." I wouldn't mince around with that one.

DR. ORNISH: Well, I would disagree with that, even though you might find that puzzling, given what I do, but I think that we don't want to be the food police, and I don't think that high fat snacks should be eliminated, I just think that -- I mean, kids don't necessarily have to eat such a low fat diet.

They eat way too much fat, they eat way too much sugar. They should be limited, clearly, but to eliminate them, there is kind of a fascist quality that people tend to associate --

DR. GORDON: I'm interested in eliminating the sale and advertising of any of that stuff.

DR. ORNISH: You are not saying "limit"? We are agreeing about limiting. You are talking about eliminating.

DR. GORDON: Yes, that's right.

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

believer in freedom of choice. I think we are going to really hit a major land mine if we talk about eliminating those. We are going to be the food police.

DR. GORDON: Actually, the Center for Science in the Public Interest has recommended it.

DR. ORNISH: I know that, I work with them.

DR. GORDON: I know. Other consumer groups, many parents groups. All I am saying is it is not as if we are completely out of the spectrum.

DR. ORNISH: The Center for Science in the Public Interest is the perfect example of someone who has been considered the food police. That is what people call them.

DR. GORDON: Understood.

DR. ORNISH: And I work closely with them, I know, but I don't think that is advisable here.

Effie.

DR. CHOW: I agree with Jim. I think we should use strong language. If they want to bring Twinkies in, that's their business, but not to have it for sale in the schools, et cetera. I bet there could be in collaboration with parent groups and with groups that we

know support that.

I think we are pussyfooting around different things too much.

DR. ORNISH: We are hypocrites if we do that.

DR. CHOW: Excuse me, I haven't finished, Dean.

DR. ORNISH: Okay.

DR. CHOW: Thank you. I think we shouldn't worry about land mines all the time and that we need to put out some strong wording, and this is not like promoting, well, I don't know, Sanskrit you mentioned, but there is nothing wrong with that either.

But anyway, I go back to thinking that we are here to represent the people, not just our thoughts and not just out own experience. We have heard a lot about these, and we need to really put out our vision and be strong about a lot of these factors.

MS. AXELROD: Just a little history. The reason that we put this in this context of incentives is because we have discussed how schools derive so much money from having these in their schools that even if they, in principle, agreed with this, that they need incentives to address the issue of the funding that they

get from them.

SISTER KERR: I really only want to make comments, and I have to say, we have to give thought, in my opinion, to what Dean is saying.

To me, particularly since we haven't done it anywhere else, this is such a dramatic statement given the tone of the whole report, that we are into situational ethics, we are into huge philosophical decisions and discussion here about freedom of choice.

If anything, my radical statement would be the fact that we trade a computer for a child's mind to advertise to them. So I would be into something really dramatic, like every school better rewrite its ethical codes and relook at its moral statements. So I don't think we can put those in there.

This is a big deal when we eliminate choice. I think an educational, philosophical position could be that you teach a child how to make a choice, and there is plenty of data, which is what disturbs me, that in advertising, you almost start to get into whether or not we lose the mind's ability to make a choice.

So, these are humongous, and I have the passion

of feeling that Jim and Effie have about this, but I don't know if it's the right thing to do in this case.

DR. ORNISH: Again, no one is more committed to people eating healthier than I am. At the same time, I can just tell you, from 25 years of doing this how easy it is to get painted into a corner and say, "Oh, the Commission is going to take away the Girl Scout cookies, they're going to take away the bake sales, they're going to be the food police, they're going to say you can't have a cookie or you're going to die.

I'm not going to raise my son not to ever eat cookies. I mean, I don't think that is a big deal to have an occasional treat. The problem comes when that is all you eat. It is one thing if you have got heart, it is another thing if you are a little kid.

Clearly, we need to limit things. If we talk about eliminating them, I think we are really in an area that I am not comfortable, and I know a lot of other people aren't either.

DR. GORDON: Can we get some wording, having heard the differing opinions? Does somebody want to offer some wording that all of us can live with? Don, do

you want to offer something? Were you offering something? Or, Tom?

MR. CHAPPELL: I just need clarification from Dean.

Would you rather not have this in there at all?

DR. ORNISH: I like the idea of limiting the sale and advertising. I was actually working with the Assistant Secretary of Agriculture to reduce the amount of fat in the school lunch programs about five years ago, and we went around and we were hearing testimony from various people saying they would go to McDonald's because the food was so much healthier than what they serving in the schools.

Look, there is a lot of room for improvement, and I would be the first to say that we need to do it. I am only saying what I consider an extreme position, of saying I don't think we should legislate that only healthy food can be served there, but I do think we need to change it, improve it, and incentivize it in a better direction. There is a lot of room for improvement.

MR. CHAPPELL: Don't you have the latitude for that, the way it is written now?

DR. ORNISH: I like the way it is written now.

DR. LOW DOG: I do, too.

DR. ORNISH: I don't have any problem with it at all.

DR. GORDON: So does that mean that you can live with this, Tom?

MR. CHAPPELL: I can live with this.

DR. ORNISH: Can you live with this?

DR. GORDON: I can live with it. I will make one final comment, however, that I don't think any food should be advertised in schools, frankly. I went to a school where they advertised any food, and it was fine. We had the school lunches. Some of it was healthy, some of it wasn't healthy.

DR. LOW DOG: You're still alive.

MR. CHAPPELL: Where do fishsticks come from?

DR. GORDON: If you wanted to buy unhealthy things, you could go off, buy unhealthy things at lunchtime. You could buy unhealthy things anytime during the day. You go off campus.

I am not saying you shouldn't have cookies. I'm not a cookie fascist. I like cookies, but schools

should set an example so that you have a little bit of sweet, a little bit of fat, but you don't push the stuff. That's my problem with it, that when there are companies coming in that are making a lot of money off these kids and getting them habituated to eating this stuff, it should not be the function of the school to say it's okay.

DR. ORNISH: I think that is pretty well covered here by saying "limiting the sale and advertising of high fat snacks."

Can we all agree to that and move on?

DR. CHOW: Yes. I can live with that, too.

DR. ORNISH: Great.

DR. CHOW: But idealistically, I like the other, but I will live with it.

DR. ORNISH: I mean, clearly, we live in an imperfect world.

Would that cover your suggested changes? All right.

SISTER KERR: My last comment is, it is so painful to me, Jim. It is a painful thing, and it's complicated, and I wish we could get to a way of making

recommendations that would get to some of these true dilemmas in the whole nutrition issue. It is so complicated.

DR. GORDON: Just one more try. What about limiting the sale, and eliminating the advertising? I don't know, it's just the advertising, it seems to me, there is something so pernicious about it all. But if everybody else can live with it.

DR. ORNISH: Yes, I would go with that. I would go with that.

DR. LOW DOG: I could eliminate the advertising.

DR. ORNISH: We could say "limit the sale and eliminate the advertising of high fat snacks." Yes, I could live with that.

DR. CHOW: But that's what we said in the first place, was to eliminate the sale and --

DR. ORNISH: No, no. It was "eliminate the sale and --

DR. GORDON: Eliminate both.

DR. ORNISH: I mean, even Coca-Cola or Pepsi took their soft drink machines out of schools recently

because they were feeling the heat.

Can we all agree with that? All right.

No. 5. God, I thought we were just going to breeze through these. Little did I know. "The Commission recommends that CAM wellness and prevention activities be included in all federal worksite wellness in health and prevention programs, and federal health coverage plans.

How about if we say scientifically proven and effective CAM wellness and prevention activities? Is that okay? Or, just safe and effective. Safe and effective is easier to say. Is that okay with everybody?

DR. WARREN: Read it again.

DR. ORNISH: It would say, "The Commission recommends that safe and effective CAM wellness and prevention activities," blah-blah-blah.

DR. GORDON: Dean, let's think through a little bit. Say what you are thinking of when you say that.

DR. ORNISH: Well, it is deliberately vague so that we don't have to get into specifics, but it protects the Commission from any charge that we are saying that everybody should sit under a pyramid and do crystals and

have oral chelation in all federal worksite wellness and health promotion programs, that's all.

When mandating something in federal agencies, you have to be careful. Is that okay?

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

[No response.]

DR. GORDON: Okay, good.

DR. ORNISH: No, wait. Do you have a comment? Turn your mic on.

DR. BERNIER: With the term "federal worksite wellness and health promotion programs," is that going to be interpreted as endorsing anything in particular?

DR. ORNISH: Hopefully not. That's why it is so vague.

DR. GORDON: I think the modifier is the "safe and effective."

DR. ORNISH: Yes, endorsing anything that is safe and effective. Then again, you marginalize people. You say, well, why wouldn't you want things that are safe and effective on the worksite, unless it is because of an economic issue. We could even say "safe, effective, and

cost effective," but that may be going too far.

No. 6, "The Commission recommends that in consultation with the business community, incentives be developed for employers to include CAM wellness and prevention in worksite wellness programs and health coverage and decrease premiums."

I think I would put "safe and effective CAM wellness and prevention."

DR. FAIR: What does "in consultation with the business community"? To me, that means you go in and you say, "We would like to do this program," and the business leader would say, "How much," and that would be the end of the conversation. Why don't we just eliminate "in consultation."

DR. ORNISH: Well, you can't force them to. You can't mandate that --

DR. FAIR: We're just making a recommendation. We're not saying we're forcing it, we're just making a recommendation.

DR. ORNISH: Well, it just has a tone of inclusivity, as opposed to Big Brother.

DR. GORDON: Are there other thoughts about

this one?

DR. LOW DOG: I think it is important --

DR. ORNISH: Hang on, Tieraona.

Are you comfortable with that?

DR. FAIR: I just realized how much more mellow you have gotten than I have over the years, with the food police and the consultation with business community.

DR. ORNISH: Are you saying I have sold out. Those are fighting words.

DR. FAIR: No, I don't think you have sold out. I just think that if we are going to attract any attention, that we have to be stronger in what we come up with.

DR. ORNISH: So, what would you like this to say?

DR. FAIR: I would just cut out "in consultation with the business community." Because we are recommending that. That doesn't mean they have to do it.

DR. ORNISH: Okay, Tieraona.

DR. LOW DOG: I just think that it's important to build bridges, and not all of these businesses are GMs

or Fords. Some of them have three and four employees. I think that you have to do it in consultation with the people that you're trying to bring on board.

DR. ORNISH: Yes. We can learn from them.

DR. LOW DOG: They may have better ideas. They may have good ideas for what would work that somebody might not think about, or there may be limits or obstacles. I don't know how you could make the recommendation without being in consultation with them.

DR. FAIR: [Inaudible] -- talk to them.

DR. ORNISH: Well, if you talk to them, then that is what it means. Is the word "consultation" the problem? Have a discussion, would that be better?

DR. TIEN: I think "discussion" is better. I feel comfortable.

DR. ORNISH: Okay. Bill, would you be more comfortable?

DR. FAIR: Yes, I agree.

DR. ORNISH: Because "consultation" to you has an approval quality, that we would have to get their approval for it?

DR. FAIR: Well, you would have to get the

approval anyhow.

DR. ORNISH: Well, that's the point.

DR. FAIR: I think that one could have incentives for the employers, in pointing out to them the advantage in wellness and prevention programs. I could live with -- what was the other term, "discussion"?

DR. ORNISH: Discussion.

DR. FAIR: Live with "discussion," I guess.

DR. ORNISH: Bill, let me just take one minute just to explain to you, it's not that I have gone soft. I used to be much more of a zealot, and I learned that it really turned more people off than it helped, because even more than being healthy, people want to feel free and that they're choosing and they're in control. As soon as I tell somebody, don't do this, and don't eat that, and don't smoke this, and do this, and do that, they immediately want to do the opposite. It's just human nature. It goes back to, don't eat the apple, and that didn't work very well either, and that was God talking.

So I have just learned to try to give people the information, give them the support, and make sure

they feel free to chose, and paradoxically they are much more likely to make and maintain these choices than if they feel they are doing it because someone is pushing them to do it.

DR. LOW DOG: Isn't that partly what we said part of the motivation for people using complementary and alternative medicine was, they wanted to feel empowered, they wanted to make their own choices, they wanted to be in control, and here we are trying to take it away.

DR. ORNISH: Precisely. Exactly. It's not that I feel any less passionately about these things, it's just I have learned to be more skillful about them than I used to be.

DR. FAIR: Well, it's not taking away. We have a number of small businesses in our center in Soho, and we were approached by small companies, six or eight people, and when it got to talking with the management, they said, no, we can't afford that.

So that is all I was saying. I mean, it wasn't the employees that were opposed to it, it was the employers.

DR. ORNISH: So you can't force them, though.

DR. FAIR: You can't force them into it, that's right.

DR. ORNISH: All right, No. 7. Thank you for your comments, everyone.

"The Commission recommends that the Secretary at DHHS establish a task force to develop strategies to incorporate CAM wellness and prevention activities in federal programs such as," blah-blah-blah.

Any comments?

DR. GORDON: Dean, can you just lay out the reasoning. In both of these are task force recommendations. Why are you recommending a task force rather than specific implementation now, and what are the pros and cons? What did you weigh when you made that decision?

DR. ORNISH: Well, because we don't have specific recommendations. I mean, these all have their own individual needs. Meals on Wheels provides meals to elderly people or disadvantaged people. They may need more fat diet if they are malnourished.

There is such a spectrum of needs here, that it is hard to make recommendations that apply equally to

each of them. So that's where that came from.

DR. GORDON: A second question related to both of these, just for simplification, is it possible that the same task force could address both of these areas, the ones in No. 7 and No. 8?

DR. ORNISH: Well, they could, they're just that much more diverse. I mean, what tied together Recommendation No. 7 is it has to do with families, mothers, children, infants, as opposed to veterans and things like that. One is more facilities-based, and the other is more --

DR. LOW DOG: Right, but we do have maternal and child health programs and school health programs under No. 8.

DR. ORNISH: That's true. It could be combined. It's just going to make a longer list.

DR. GROFT: Actually, Dean, as you prepare a workshop and design one, you could think of various ways to do this, that you have a number of breakout sessions for each of the groups, and then bring the group back in for a general session. We do it all the time. It could be done.

DR. GORDON: I think it would be important to get an energy behind this recommendation in the text, conveying the sense that this a wonderful opportunity to really take a look.

I think the other thing that needs to be incorporated is what you have down below, is the recommendation for demonstration projects. I am wondering, are you planning to incorporate that in both?

DR. ORNISH: Well, I thought that it would come out of the task force, that would be one of the options. The task force might recommend to do a demonstration, or they might recommend that there is enough evidence already to implement. I think it is going to vary. Some things there is more evidence for than others, and some they need to gather more data.

DR. GORDON: Let me just finish the one thought. My suggestion would be that you include both of those thoughts, at least in the text so that we have a sense of what the job of the task force would be.

DR. ORNISH: Okay. Thank you.

DR. CHOW: I have a question. Could these activities of the task force be through the Center for

Complementary and Alternative Medicine? No? It has to be through the Secretary of DHHS?

DR. GORDON: Do you want to address that?

DR. GROFT: The National Center is so research-focused that these activities are pretty much --

DR. CHOW: I'm talking about the center that we are recommending.

DR. GROFT: That's not a center. It would be an office of some type.

DR. CHOW: Yes, the office of something.

DR. GROFT: Yes, you could extend that to be the sponsoring organization. It could be the surgeon-general, it could be the Secretary, it could be a White Commission, a presidential task force to look at these things.

DR. CHOW: The point of my question was, can it be stated that it could be function of the -- what are we calling it?

DR. WARREN: CAM Central.

DR. CHOW: CAM Center, that's what I said.

DR. GROFT: I think that was the idea behind giving it to the Secretary of DHHS, that we didn't want

to lose it. We want someone to do it, and we did not want to wait until there was an office, if there is an office. I think that was the idea behind making it a Secretary of DHHS activity.

But I would hope that if there is an office, that they would be involved in something like this.

DR. WARREN: Our Potential Responsibility to CAM handout you all got, this is covered on page 7 of that. This is covered on page 7 of the Potential Responsibilities and Activities of the CAM Office. I had it listed when I read this on CAM Central, and then we got this from Joe today.

I like the aspect of putting it in with the possibility of the Secretary of DHHS because if, for some reason, CAM Central doesn't get funded, or doesn't get created, then at least we still have the door open there.

DR. ORNISH: Charlotte, you had a comment?

SISTER KERR: Two comments. The first is, I think Access and Delivery folks did some good things when they put some timetables in their recommendations. The question would be whether or not it is appropriate or desirable to suggest that DHHS establish a task force,

for example, and offer a certain amount of time. So that either can be discussed or dropped. Maybe no one else thinks that is important.

My second thing is, and this was discussed when the Wellness met by telephone, I was at least the one person I know of who felt that we should have a specific recommendation for a demo project. I suggested the VA system. I said that I felt it was a system that is contained. Number one, the people deserve it who are veterans, and we have some good data from people who have presented of what is going to happen in this system. This country is in for a big shock in terms of cost.

I thought something was going to be written up as a demo project or a pilot project.

DR. ORNISH: It may very well be that the VA is a good place to do it, but I think if we are going to say that there should be a task force to sort this out, it would be undercutting them to then mandate that this is what they do. So I think we should either mandate it or have a task force, but not do both.

DR. GORDON: What I don't see here is the armed services, and I think that this is a really important

area that we need to be addressing, the wellness programs for the armed services, DOD.

DR. ORNISH: Yes, we should add that. That's a good point. Thank you.

DR. JONAS: I was going to actually mention that, that the DOD has major emphasis on health promotion and wellness. They have programs that look at this, specifically, and would do it on their own if we recommended it.

The other thing, too, I was going to suggest is that, at the recent Georgetown Policy Conference, there were a number of working groups, and I was on the Public Health Working Group. They actually developed a number, I think, of good suggestions for the facilitating, looking at CAM and its relationship to public health issues, including things like 2010 and that type of thing. It might be worthwhile looking over that report to see if there is language, either for background or recommendation materials that might be more specific, focused, and useful, perhaps. So that was just a suggestion.

That may be true for some of the other things

in that meeting also, because they were looking at policy issues. It might be worthwhile just to look it over and say, are there things that are missed; what was the emphasis, that type of thing, for this report. I think a lot of what they did very much paralleled what we are already doing here.

SISTER KERR: I just want to follow up. I guess I felt pretty strongly about my recommendation, and at that point, I don't guess I remember, or I missed, the idea of the task force. All of us, I think, fluctuate at times about how specific we want to be or visionary, and Bill's statement, and I want to get that in there.

I guess I don't want to wait on the task force. We have got so much data. We are going bankrupt. We have got a lot of people who deserve some healing and kindness and help, more than, I'm sure, they are already getting. Why can't we make a recommendation?

DR. GORDON: I think we can. If you would like to make a recommendation, we actually have some minutes. So do you want to take a few minutes while we go, and then make a recommendation for demonstration projects?

DR. ORNISH: I mean, the easiest way to do it

would just be to say that the Commission recommends that the Secretary of DHHS develop strategies to incorporate safe and effective CAM in wellness, prevention in health care and delivery programs such as, blah-blah-blah.

Is that what you have in mind? Or, do you want to take even "such as," and just say "at the Department of VA, community and migrant health centers"? Is that what you want to say?

So instead of "in health care delivery programs, such as the Department of the VA," et cetera, you would just say "in health care delivery programs, including." In other words, that it would be a mandate.

SISTER KERR: The reason this got left, as I understood, on the phone discussion, was, I don't know enough about research. For example, if I want to help the veterans and I know what the system is going through, but I don't know enough, for example, on a project, we would have to pick a particular a problem, a particular kind of disability.

DR. GORDON: I think all you have to do is name the population or the place, and that is to say that there should be a demonstration project incorporating

safe and effective CAM wellness programs. I would say large-scale demonstration -- I'm sort of riffing on what you are saying -- for both veterans and in the Department of Defense. I mean, those are very obvious places. They are very needed.

The Defense Department has actually been having wellness programs, including CAM therapies, for 20 years. I worked in one of them, helped out with one at Walter Reed 20 years ago. It's a great place to do it, and it could be very high visibility, and it's real important.

DR. ORNISH: The Department of Defense funded us to train the Walter Reed Army Medical Center here. We can actually order people to meditate now, which is great. Give me 15 minutes of meditation now. Sir, yes, sir.

MS. AXELROD: Can I just add some clarification about the reason that we put in a task force? There certainly are other options, but we wanted to specify somebody to be responsible for this to occur, and that is why we put the Secretary of DHHS. However, many of these programs are not in HHS.

DOD, the VA hospitals, Meals on Wheels, several

of these others, by establishing a task force, the Secretary can actually bring people from other departments together, because it is either that, or we specify the Secretary of DOD, or go through the litany of all of them.

So that was one of the reasons. The other reason, of course, is just to bring people to the table, to build support, and to share strategies because many of them are already doing some of this. DOD can tell the VA what they are doing, and vice versa. So that is the reasoning behind that.

SISTER KERR: All this is good, even Dean, when he gave his little recommendation how it could be written, and then Jim amplified on it.

I guess what is in my mind so much, and what Corinne just said, and you could write it with that in mind, is, I think a lot of what Dannion actually has presented. He gave us a lot of good data, if it's all accurate. I think if it is being done, it certainly hasn't been focused enough to touch on to that. I only know what I have had testified to.

So it is still a statement of, you could have

the task force, and we could also just say we feel that one possible recommendation that we feel strongly about is this one. And if the group doesn't agree, it's okay. Well, I don't know if it's okay or not, but we can discuss it.

DR. GORDON: It is entirely possible to recommend the task force and recommend demonstrations. One does not preclude the other. Do you want to put it into words, or do you want to take what we --

SISTER KERR: I think a basic statement like Dean said, and amplify it with whatever the other areas, sounds like it is okay to me.

DR. CHOW: I have -- for Charlotte's recommendation, too, because I agreed with her when she made that recommendation. I have worked with the Armed Forces about 15 years ago with Chinese medicine and qi gong. Also, the VA, I have worked with them.

If you got research or a study through the VA, it can go right through the whole system. It is a monolithic system. That is really great. So perhaps we could put a time frame, again, that we would like to have it done within such a time.

No? No time frame? Well, there was a discussion of time frame in the previous one.

SISTER KERR: Thank you for that comment. Let's try writing what we heard, to start with. Dean, can you repeat your statement?

DR. ORNISH: Well, I will say I am actually very happy with it the way it reads right now, but if you are trying to make it stronger, you would just simply take out the words "establish a task force to develop strategies" --

SISTER KERR: No, excuse me. I was leaving 7 and 8 alone, and adding another one that would just be a separate statement for a recommendation to do a demo project within the VA system or Armed Forces, or whatever, to include, as you said, safe and effective CAM practices.

DR. ORNISH: What question are you trying to answer?

SISTER KERR: I am trying to make a recommendation.

DR. ORNISH: No, no, no. If you are doing a demonstration project, you are trying to demonstrate

something. What are you trying to demonstrate?

SISTER KERR: That safe and effective CAM practices -- that is why I was saying I didn't know, would help what within that population.

DR. ORNISH: Well, that's the whole point.

SISTER KERR: Well, that's where I started way back.

DR. ORNISH: You have to have a hypothesis to test.

SISTER KERR: Well, I am being told I don't.

DR. ORNISH: Pardon me?

DR. JONAS: The particular item in the demonstration project would be determined by the VA, and the particular modalities and conditions that they need to look at. So I don't think that would go in a recommendation.

DR. ORNISH: Well, that is why we have a task force, because if you are not going to make a specific recommendation for a specific demonstration, then you have to delegate it to someone else to do that.

DR. JONAS: I understand, but I think what Charlotte is saying is that the task force is fine. That

is a great recommendation, but she would like an additional recommendation that is more focused on a demonstration project, rather than a general suggestion for a task force to look at strategies, which could be anything from sunrise to sunset.

DR. ORNISH: Okay. So how about if you say that at the end of paragraph 8, add a sentence that says something to the effect that this task force should design a demonstration project?

DR. GORDON: I think she is saying that there is a separate track, there is the task force track and there is another track for demonstration projects.

DR. ORNISH: I get that, but the point is that you have to either say what the demonstration project is, or you have to say who is going to design it. So who better to design it then the task force that is spending time looking at all this stuff. I mean, you could ask the Secretary of DHHS to design it, but they're not going to.

DR. JONAS: The VA would design it.

DR. ORNISH: The head of the VA is certainly not going to design it. They could, but they won't.

DR. JONAS: If we recommended it to the VA, the VA would delegate somebody.

DR. CHOW: They would delegate, yes.

DR. ORNISH: Again, what are you trying to do? I mean, demonstration projects are nice, but what are you trying to demonstrate?

DR. JONAS: Well, a wellness intervention, a CAM and wellness intervention. I mean, it depends on what you want.

DR. CHOW: For example, where they have reached a plateau with their people, and having worked with them, a lot of them have reached a plateau that can go further if they included CAM.

DR. ORNISH: A plateau in what?

DR. CHOW: Mobility.

DR. GORDON: Be specific in terms of research design.

DR. CHOW: They can decide what that is, what is their pressing point, what haven't they gotten the best --

DR. ORNISH: But we have to say something. If we are going to recommend a demonstration project, we

have to give some indication of what question we are trying to answer.

DR. LOW DOG: I think I would like to support the demonstration project. It has to be demonstrating something. We have to have a question that you are going to develop a demonstration project around.

DR. ORNISH: I mean, this is a little bit backwards. Normally, you have a question and you say, let's design a demonstration project, not, oh, we would like a demonstration project, what question can we come up with.

DR. JONAS: Okay, we have decided over here. We want it on quality of life and quality of dying.

DR. GORDON: A demonstration project of safe and effective CAM practices, enhances sense of well being, locus of control, and decreases stress in members of the Armed Forces, and then the population that uses the VA hospitals; two demonstration projects, something like that. I think if we can leave it general.

SISTER KERR: Quality of life and quality of dying.

DR. ORNISH: One at a time. I'm sorry.

SISTER KERR: Quality of life and quality of dying.

DR. ORNISH: Well, I'm not saying that we need to suggest a demonstration, I'm just saying that we either need to suggest one, or we need to delegate to someone else to suggest it, that's all.

SISTER KERR: You are saying that you think it should go to the task force who would be the people to create the demonstration project, and we are saying that perhaps there is another alternative, and that we may want to make a separate recommendation that would go through the VA, and that we wish that they would apply the safe and effective complementary medicine practices to issues such as quality of life, quality of dying, and Jim said something else. So this is what we are debating right now.

DR. LOW DOG: My only comment would be, if we are going to make a recommendation for a demonstration project, that we are very clear and thoughtful what we are asking that to do.

DR. ORNISH: Exactly.

DR. LOW DOG: Because the task force may be

able to do a better job of coming up and identifying, working with the VA, asking them for their input and looking at their statistics of how it would be most beneficial to them.

DR. ORNISH: That is the point I was trying to make. Thank you. That was the point I was trying to do, but I didn't do it as eloquently. What if we just put a sentence at the end of paragraph 8, that we encourage demonstration projects to be conducted in this area? Do you want to just leave it like that? And we don't have to say who is going to be --

DR. CHOW: But I think not everything must go through the task force.

DR. ORNISH: I didn't say that.

DR. CHOW: Well, when it is in this recommendation, it does. It goes through the task force. The thing is, if we recommend a demonstration project, they might decide to set up a task force to do that, or the director himself might say, "Hey, that's a great idea. Okay, I'm assigning somebody to do this," and they can do the survey as well. They have staff that could do this.

DR. ORNISH: Why don't we have a separate recommendation for No. 9, that says something to the effect, we encourage one or more demonstration projects to be conducted to evaluate the safety and efficacy of CAM wellness and prevention activities in these various things that you have got listed here.

Would you all be okay with that?

DR. CHOW: No, it is not to evaluate the safety and efficacy.

DR. ORNISH: Then what is it?

DR. CHOW: It is using safe and, whatever the --

DR. ORNISH: Well, if you already know it is effective, then you don't need to do a demonstration project.

MR. CHAPPELL: No, it is to evaluate the benefit on the vulnerable populations.

DR. CHOW: The impact, that is the word, of the use, of the safety and efficacy, to see whether it increases their level of wellness, and quality of life, and mobility, and depression, and all of that.

MR. CHAPPELL: I mean, the study is as much to

find out just how far-reaching the benefits are itself. So I do think a separate recommendation is appropriate, Dean, if you can craft it.

DR. ORNISH: So, would all be able to live with a separate recommendation that says, "The Commission recommends that funding be provided to conduct demonstration projects to evaluate the safety and efficacy of CAM wellness and prevention activities in the Department of Veterans Affairs, community migrant health centers, maternal and child health programs, school health programs, and the Department of Defense"?

MR. CHAPPELL: No.

DR. GORDON: No. I don't think people are being that broad. I think that that may dilute it. I think that we are saying there are two places, clearly, where there has been interest in this work for many years: Veterans Affairs; Department of Defense. I think if we focus on those two, people will find a very receptive audience. If we focus on some of the other centers, they are going to say, what is this all about. That is where the task force is really important, to help focus activities.

MS. AXELROD: Can I read a revised recommendation to see if this will work for everybody? "The Commission recommends that funding be provided for one or more demonstration projects to utilize safe and effective CAM practices in federally funded wellness and health promotion programs."

MR. CHAPPELL: If I am understanding, what we are trying to do is measure the impact of safe and effective CAM practices, so I would insert the words "impact of."

DR. GORDON: I would like to remind us we have nine minutes. So can we agree on a wording, and then see if we have a consensus, and then move on to the final recommendation?

DR. ORNISH: I can agree with what Corinne just said? Do I have a second?

SISTER KERR: No. I would like to say, "The Commission recommends that funding be provided for one or more -- this is what Corinne is saying -- demonstration projects to evaluate the impact of safe and effective CAM practices within the VA and DOD population."

DR. ORNISH: We can live with that, I think.

SISTER KERR: You got that, Corinne?

DR. ORNISH: Is that okay?

MS. AXELROD: Yes, but I just want to question that you are specifying the VA and the DOD, where other people would strongly advocate that it be at a community migrant health center, or it might be some other program. I am just wondering if you all want to specify that, or add others, or how you want to address that.

SISTER KERR: I think the group does have to decide that. I specifically had some insight in the sense of helping the VA folks. Other folks have been talking Department of Defense. So I can't speak to that one.

DR. ORNISH: I think I would say, after hearing all this, while my initial reaction would be to include all of these other things, in these times that we are living in, that there might be something to be said for including the DOD and VA by name, to the degree we want to try to make this more palatable and less whimpy, because a lot of people think CAM equals whimp. So if we can get the DOD and VA in there, then suddenly we have the macho factor alongside it. So I would say, God bless

this recommendation, and God bless America.

We have to finish No. 9. Oh, Charlotte, would you read yours again?

DR. GORDON: Let me just check. Are we okay with this recommendation? We have consensus?

[No response.]

DR. GORDON: Okay, great.

DR. ORNISH: So, Charlotte, would you read it again so Corinne can copy it down.

SISTER KERR: Corinne had started, "The Commission recommends that funding be provided," and she suggested "one or more demonstration projects to evaluate the impact." Is that correct?

MR. CHAPPELL: That's right.

SISTER KERR: "Of safe and effective CAM practices in the VA and DOD population." I would like to acknowledge the comments I have received through the ethers in writing this.

DR. ORNISH: Recommendation No. 9, our last one. We have got a few minutes left. "The Commission recommends that the Secretary of DHHS establish a task force to develop strategies to incorporate CAM wellness

and prevention activities in the nation's hospitals and long-term care facilities, and programs serving the aging and dying, and those with chronic illnesses."

Is that too redundant with what we have got already? Can that be combined with one of the earlier recommendations?

MS. AXELROD: One is federal, one is not.

DR. ORNISH: One is federal, one is not. Okay.

Comments?

DR. BERNIER: You might well want to have people who work in the various wellness and prevention activities to be part of that population that is being studied. That would be a way of getting an additional people involved.

DR. ORNISH: Well, we are not talking about doing a demonstration or study here. We are talking about actually incorporating safe and effective CAM wellness and prevention activities.

DR. BERNIER: You say in the long-term facilities, et cetera. I was wondering about just involving the group of people who are there, the self-care providers. That is just a thought.

DR. ORNISH: I think it is a very good thought. I am just debating whether it goes here or in the text, that's all. But it is a very good thought.

If you all don't mind, we could add safe and effective.

MS. AXELROD: It is already in the text. If you look at 3.13 through 3.19.

DR. ORNISH: Page 12, line 3.13 to 3.19. Other comments or questions, or concerns, or thoughts, or feelings?

DR. GORDON: I just wanted to circle back to one note I had on the text, which is around 306: "Should be easily integrated into clinical management." We need some sense of what that means, the integration of these practices, and also the expansion. That is just a sidebar here.

DR. ORNISH: Okay, thanks. Anything else? Whoops, we are out of time.

DR. GORDON: Where are we, Dean?

DR. ORNISH: I think we are done.

DR. GORDON: Where are we with No. 9? Okay?

DR. ORNISH: We were going to add "safe and

effective," but I think other than that, we're okay. Then we never resolved the issue about putting Issue 1 and 2, flipping them back the way they were before.

Bill is not here, is he? Is he coming back? Any other thoughts about that particular issue, Issue 1 and Issue 2.

DR. GORDON: Julia wanted to say something.

MS. SCOTT: I remember we had a long discussion about this on the telephone.

DR. ORNISH: Right.

MS. SCOTT: The reason why we decided to switch 2 with 1, and it was to go from the macro to the micro. Our first recommendation, we wanted to address the nation. So Recommendations 1 and 2 were focused on the nation, and then we subdivided to the subpopulations.

DR. ORNISH: Right. We went from the general to being specific.

MS. SCOTT: In terms of importance, we picked children as the first important population. So that is why it ended up as 2, not to diminish the recommendation, but to have more order with this section. So that, we talked about national objectives for every citizen, and

then we talked about the subpopulations, with children being the top priority of the other subpopulations.

DR. ORNISH: Yes. That is exactly right.

MS. SCOTT: It made sense to me then, and it still makes sense to me now. I think switching it now kind of throws the whole thing off kilter. I say that, understanding that the whole order of the report, and outline of the report, is still up for discussion. But I think that was our sense when we were talking on the phone on why we ordered it in this way.

DR. ORNISH: Well, you're right, that is why we did it, and it certainly makes more sense from a structural standpoint.

But, Bill, given how strongly you feel about it, I want to make sure that you feel regarded. If you feel like you would rather have this moved up, I mean, I would rather sacrifice the structure for the content.

DR. FAIR: I think nothing in this book is more important to me than that, to be honest with you. I think that is the future of our nation. When I look at the problems down the road from obesity and lack of

exercise, it is astonishing what that will do to our national health care bill in 20 years. My approach has always been the best defense is a good offense, and go with the thing that is most important to you first.

DR. ORNISH: Okay. Well, in deference to you, I would recommend that we just do that.

DR. FAIR: Thank you.

DR. ORNISH: I think we should each get one thing that we can say, that's really important to me.

DR. GORDON: We have differing perspectives. Do we have a consensus on this? Should we try it?

Julia, you had another voice. Should we try it the other way, with children first?

MS. SCOTT: I am perfectly open to trying anything. I just thought I would remind everybody we did spend a lot of time on this, and that was our rationale. It is open to discussion.

DR. GORDON: I think maybe some of this can be addressed in the text. The text can move from this macro level, and then come down on the side of children, and then move back out again to the healthy behaviors.

DR. ORNISH: Well, I would actually take it a

step further. I completely agree, Julia, that that is why we did it, but given how strongly Bill feels about it, out of deference to Bill, I would say, let's just make that the first, and that way, the first recommendation will be the one that he care the most about.

DR. FAIR: Well, thank you. I appreciate it. To me, the whole field is so depressing, to see the children, particularly young women, who are taking up smoking now in a big time way. We are just now getting the message across.

DR. GORDON: Great. Dean, thank you very much for your heroic efforts this afternoon.

DR. ORNISH: Thank you all.

Session Summary

DR. GORDON: Thank you everybody. We have come through on time. We have done our work. We have consensus. We added a recommendation for demonstration projects. We reversed the order of Issues 1 and 2, and we made several small changes in wording, and we discussed the issue of consolidating task forces. That is where we are.

Steve, do you want to conclude?

DR. GROFT: George DeVries has sent us a number of comments on reimbursement and coverage, and other issues that he would like us to look at in his absence. So we gave you those this afternoon.

Tomorrow, during the Coverage and Reimbursement discussion, Maureen will lead the discussion, but George will be piped in through our sound system. So he will be here in voice to help guide us as well. He has done an awful lot of work up to this point for this section.

I have one other piece of information to hand out. It is something Dr. Singh had asked that we distribute regarding Ayurveda medicine, and our plans are to meet with him and discuss his concerns outside of this meeting. Several of the local commission members will travel down to the Indian Embassy to discuss with him the concerns about Ayurveda here in the United States.

DR. GORDON: Once again, thank you all. This is a great day. We really did a lot of work.

[Applause.]

DR. GORDON: We will be back at 8:00 tomorrow morning.

[Whereupon, at 5:00 p.m., the meeting was recessed to reconvene the following day, Friday, December 7, 2001, at 8:00 a.m.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE: White House Commission on Complementary and Alternative Medicine

HELD: December 6-7, 2001

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

DEBORAH TALLMAN, Court Reporter