

1 MR. CHAPPELL: Well, that is my sentiment on
2 this particular recommendation. If you wanted to
3 maintain the idea of the policy board, the recommendation
4 might be strengthened by saying, "to include at least the
5 following." That would carry forward at least the things
6 that the commissioners feel strongly about, as we have
7 had time to review this.

8 As a standard recommendation I can't accept it
9 because it is a vessel without any content.

10 MS. LARSON: So you would add some specific
11 language just saying to include what?

12 MR. CHAPPELL: I would defer to your fine
13 committee to identify those.

14 DR. FINS: Before we get to this, I see the
15 point and, again, this does not quite follow from what we
16 were just talking about.

17 So I think the bigger question on the table,
18 which again initially many of us hoped that the access
19 and delivery and coverage and reimbursement group would
20 be a single group because many of us felt that coverage
21 and reimbursement was really whether or not there would
22 be entitlement to various things and it would be whether

1 it was covered or whether it was reimbursed, not whether
2 you had access.

3 What we were trying to conceptualize was, even
4 if you had all the money in the world and you had no
5 limitations on your funding stream, would you have a
6 system that would provide access and delivery of good
7 services.

8 So I think whether or not there should be an
9 entitlement question really, in my view, comes under the
10 Coverage and Reimbursement section. We did not address
11 that.

12 Joe?

13 MR. PIZZORNO: Being part of this committee
14 this is kind of an awkward thing to say but I think I
15 need to say it. I really like the text. I think we did
16 a good job on the text. I look at the recommendations
17 and I don't feel like they reflect what we said in the
18 text.

19 So for example, No. 52, I think it would be
20 something like: "The Commission recommends that in order
21 for the public to have access to safe and effective CAM
22 therapies, that practitioners should be regulated and the

1 forms of regulation that are appropriate are title
2 licensure and registration." I think we need to say
3 that. We said that in the text, but it got lost in the
4 recommendations.

5 DR. FINS: I think you are absolutely right,
6 and I think we did spend more time on the text side than
7 the recommendation side, and that is just a function of
8 our ability to get it done.

9 Is everybody comfortable with that kind of
10 modification, that we believe that there should be a
11 regulation, and that the categories would be mandatory
12 licensure, as we said in the text, title licensure,
13 registration, and exemption, and that there be a federal
14 body to help foster the discussions about these
15 categories as it applies to particular kinds of
16 practitioners, so that states could then go back and
17 institute appropriate regulations in their jurisdiction?

18 DR. GORDON: I am not satisfied with that as an
19 opening statement about access and delivery at all. I
20 think it has to be a statement about why people should
21 have access, a general sense of what kinds of access
22 American people should have to CAM therapies.

1 DR. FINS: You are getting us off point, Jim,
2 but what is your kind of access that you are proposing?

3 DR. GORDON: I will give you two
4 recommendations. One would be, "The Commission
5 recommends that all health care settings and providers
6 offer their patients access to CAM procedures and
7 products for which there is evidence of safety and
8 efficacy," and "access to" doesn't necessarily mean they
9 have to provide it themselves. Let me just add that.

10 The second would be, "The Commission recommends
11 that all health care settings and providers offer their
12 patients guidance in making choices regarding the use of
13 CAM as well as appropriate referrals to qualified CAM
14 practitioners."

15 DR. FINS: Let's take the first one first. Not
16 every hospital has a burn unit. Not every hospital has a
17 psychiatry service. You are saying that all hospitals or
18 facilities should provide all services to all people.
19 And then we have the question of a lot of people don't
20 have insurance so they are not in those systems. So, I
21 mean you are talking about a universal entitlement to CAM
22 modalities when we don't have universal access, and it

1 also says that things are safe and effective. Well, a
2 beta blocker is safe and effective but we don't pay for
3 that.

4 DR. GORDON: This has nothing to do with
5 payment. Let me just deal with --

6 DR. FINS: -- provide access without paying for
7 it.

8 DR. GORDON: What I am saying is if a patient
9 comes to see me I would give that patient access to the
10 burn unit or the department of psychiatry or a CAM
11 provider. That is a responsibility that I have as a
12 physician. I am not necessarily providing the burn unit,
13 but I am providing access to that unit.

14 I am not saying the wording is perfect. What I
15 am trying to get at is, we have to have some fundamental
16 statements both in the text and in the recommendations
17 that we believe that people should have access to CAM
18 services and providers.

19 That is part of our principles, that there
20 should be access. I am not saying it has to be paid for,
21 although that would be nice, but to give people access is
22 something that seems to be very much within the domain of

1 our principles.

2 DR. FINS: It seems to me that institutions do
3 not refer patients to other practitioners. It is
4 individual practitioners who refer. So it seems to be an
5 educational request and not a institutional request.

6 DR. GORDON: Let me read again. And again,
7 what I am trying to get at is based on the basic
8 principles some ideas about access and delivery which I
9 don't see in the recommendations. I see a lot of focus
10 on regulation, licensure, ways to accommodate that and to
11 approach it. I don't see anything addressing access and
12 delivery.

13 So these would be two and they sort of go
14 together. "The Commission recommends that all health
15 care settings and providers offer their patients access
16 to CAM procedures and products for which there is
17 evidence of safety and efficacy."

18 The second is, "The Commission recommends that
19 all health care settings and providers offer their
20 patients guidance in making choices regarding the use of
21 CAM as well as appropriate referrals to qualified CAM
22 practitioners."

1 For example, in the area of 85 percent of all
2 cancer patients, according to an M.D. Anderson study,
3 want referrals, want information. They want to have
4 access to these providers and their services. This is
5 the reason we are here as a Commission, and to ignore in
6 our recommendation something as basic as, this seems
7 misguided.

8 DR. LOW DOG: Conceptually I would agree. I'm
9 not sure what it means when you say, "offer their
10 patients access to CAM." I don't know what that means,
11 is all. Is it a referral? That would be a provider
12 actually making the referral.

13 "That have been shown to be safe and
14 effective." I just don't know what "access" means,
15 because if I am out in the middle of the Navajo
16 Reservation, I may want to refer you some place, but how
17 am I supposed to provide your access to that?

18 DR. GORDON: I am certainly open to amendments
19 to that to make it clearer.

20 MR. CHAPPELL: I have the same sentiment, that
21 we have got to be more direct about what we mean by
22 "access." I think the recommendations put us more in the

1 position of interdependency upon other bodies that are
2 going to have the ability to license or regulate.

3 So I think that has all been thought through
4 very well, and I welcome the opportunity to go through
5 the recommendations, but it is a paradox that we are
6 talking about access and yet we are not offering access,
7 and I think that is what Jim is trying to say, is, what
8 does the consumer mean when they say, how do I get this.

9 So we need some recommendations that say, here
10 is how you get this because, let's say I go to a doctor
11 for a specific problem, a conventional doctor, and in my
12 mind I know there may be a CAM alternative but it would
13 be very helpful to me if that doctor said, well, here are
14 your options.

15 Jim's second recommendation gets to that point.
16 I think "access" implies help the public understand how
17 they can get it, and I think we need recommendations that
18 begin to enable that.

19 MS. LARSON: Charlotte, do you have a specific
20 recommendation? We have two specific recommendations
21 right now on the table that -- and you had one, too --
22 three that are in addition, or are changes to the No. 1

1 recommendation. Do you have one, Charlotte?

2 SISTER KERR: No, but as far as from what Tom
3 is saying -- and I am going to ask the group to help me
4 with this because it is almost as if I'm feeling there is
5 a fundamental issue involved with CAM, and access and
6 delivery that I don't know if we ever get to.

7 It's like what Tom just said, people want to
8 know how to get access, and that is sort of how we are
9 talking. One of our principles is an emphasis on health
10 promotion and self-care. That is a big deal in CAM.
11 Then we often collapse into CAM as modalities.

12 Well, what are we going to deliver?
13 Acupuncture, homeopathy, chiropractic.

14 Now, this comes to recommendations. If we
15 believe one of our principles is self-care and health
16 promotion, what do we then say, under Access and
17 Delivery, that allows a person access to that? What is
18 it that is offered in the culture and the community to
19 help promote that principle that we feel is inherent to
20 CAM.

21 Of course, I probably think a lot of things,
22 but one that certainly comes forward is certainly how I

1 feel about the relationship of CAM to public health, but
2 I wonder, as we go into this, if we are not going to need
3 to think about how to speak to that better. Otherwise,
4 we are into delivering a modality and it is not complete
5 enough. I would like to ask for feedback on what I am
6 saying.

7 DR. LOW DOG: Well, it comes back almost to
8 some of the systems recommendations that you have to make
9 when you talk about access. It is not just that people
10 don't want to exercise, but sometimes it is not safe for
11 them in their neighborhoods to go out to exercise. I
12 mean, sometimes it is systems when you are talking about
13 access and encouraging communities to become involved in
14 providing safe places for people to engage in physical
15 fitness and activities. So there are all kinds of things
16 there that you could make recommendations on.

17 I just wanted to get back to defining access.
18 I think that I agree, I think the recommendations need to
19 be more direct about how we are going to address issues
20 of access and I think the regulatory aspect is important.
21 I think what I am hearing is that maybe that is not just
22 what we open with, that it is important and interrelated,

1 but maybe that is not our opening statement, and that
2 maybe some of the recommendations for access can be very
3 concrete. They can be very concrete recommendations
4 about how we would do that.

5 I think one of the other fundamental issues
6 that I just need to raise is that the question also
7 becomes access to what, and I think you want to include
8 safe and effective throughout there, because having
9 access could be to anything. I think it needs to be for
10 things that are effective, which is what Jim, I believe,
11 included in your recommendation.

12 DR. FINS: I want to make a couple points. One
13 is the referral is practitioner-based. I completely
14 agree that if someone comes into an allopathic setting
15 and encounters a practitioner, there should be
16 appropriate referral, and that is predicated upon that
17 practitioner being educated to know what is out there and
18 make the appropriate referral. Institutions do not make
19 referrals.

20 DR. GORDON: Not true, Jim. You go to a
21 hospital, you go to an ER any time, they refer you to a
22 clinic or to a practitioner.

1 DR. FINS: Who?

2 DR. GORDON: The institution in effect. It is
3 a practitioner hired by the institution.

4 DR. FINS: A practitioner, right, but it is a
5 practitioner-based referral.

6 DR. GORDON: It is a practitioner who is being
7 paid by the institution, so the institution is legally
8 responsible as well as the practitioner. I think it is a
9 distinction without a difference.

10 DR. FINS: Well, it's both, it's both. All
11 right?

12 MS. LARSON: We have an insistence.

13 DR. FINS: The other point that gets to
14 Tieraona's last comment about paying for things that
15 work, and this is where I think there is a tremendous
16 amount of overlap to Coverage and Reimbursement. In that
17 section the Commission recommends mechanisms on medical
18 effectiveness and things that should be covered. You do
19 not need to provide people with access to things that do
20 not work, and there is a whole discussion in the Coverage
21 and Reimbursement Section about how do you determine
22 efficacy and then determine what gets covered. I think

1 there is an overlap there.

2 DR. GORDON: Yes, I agree there is an overlap.
3 I'm not talking about access to things that don't work,
4 but we do offer access to things which sometimes are not
5 covered.

6 MS. LARSON: Can I?

7 DR. GORDON: Sure. Please.

8 MS. LARSON: This is a very important
9 discussion to have and we have had three very rich
10 statements made. We do have on the table three
11 recommendations, and this is a procedure or process. I
12 really would like to have other commissioners actually
13 make some comments on the specific recommendations that
14 we have been given, and also on the body.

15 If you want us to say something as a Commission
16 within the text, Charlotte, about access and delivery as
17 you understand it, or how we can enfold the principles,
18 we do need your assistance with language. I would like
19 to get back, though, to the specific recommendations.

20 DR. GORDON: Can I reword and put the two
21 recommendations in one? Would that address some of the
22 issues that Tieraona has raised?

1 MS. LARSON: We have four.

2 DR. FINS: Generally, we have done one
3 recommendation at a time, now we have got four. So it
4 might be helpful to just focus on one at a time.

5 So, Jim, why don't you go first and we will
6 continue.

7 DR. GORDON: Putting the two recommendations
8 that I made in one: "The Commission recommends that all
9 health care settings and providers offer their patients
10 CAM procedures and products for which there is evidence
11 of safety and efficacy and/or appropriate referrals to
12 qualified practitioners, as well as guidance in making
13 choices regarding the use of CAM."

14 So I am trying to say three things in one
15 sentence, that you either offer the procedures --
16 "products," I don't think, has to be in there -- for
17 which there is evidence of safety and efficacy, or you
18 provide a referral, and you provide guidance to people
19 coming into your practice or your setting to help them
20 make decisions about CAM therapies.

21 DR. FINS: I would say that, "practitioners
22 working in allopathic settings should refer patients for

1 CAM interventions that are proven safe and effective when
2 indicated."

3 The problem is that it implies an expectation
4 on institutions that do not provide this service to
5 provide this service. I think that one of the questions
6 that we are dealing with here is that generally people
7 who have gotten CAM services have not entered the CAM
8 trajectory through the allopathic system, and when they
9 enter the allopathic system, you are saying that there
10 should be sensitivity in the allopathic system to the
11 possibilities that exist in the CAM.

12 DR. GORDON: I am saying that all systems,
13 allopathic and CAM, should provide that.

14 DR. FINS: But if somebody is in a CAM system,
15 they are getting CAM therapy, and hopefully they would
16 get CAM referrals, although they may not. If you saw a
17 chiropractor, you may not get referred to a naturopath.

18 MS. LARSON: I think that, while I agree that
19 in an ideal world when all the education has been put in
20 place and all the research has been done, and we have
21 done all of that and the continuing education is there,
22 right now I could promise you that most, even well-

1 intentioned, providers would not be able to do that
2 because they don't know what is safe and effective, they
3 don't know when they should refer to it. It is
4 idealistic and something to move towards but --

5 DR. GORDON: That is exactly what I would like
6 to do, head towards it.

7 DR. LOW DOG: I think it is different to say
8 that you recommend it, versus that there is a direction
9 that you want to go in.

10 DR. FINS: "We don't know how to do that" is a
11 response. What we suggested in the later part of this
12 chapter -- and again, we were doing it from micro to more
13 macro concerns -- we were looking at integrated delivery
14 systems.

15 DR. GORDON: Let me step back from this and
16 say, if there is this much agreement, then if we bring
17 this back to the committee, we can talk about it more,
18 because I don't want to take up so much time on it here.
19 I feel it is extremely important.

20 DR. FINS: I don't think there is disagreement,
21 Jim. I think what we were saying is that we think, as a
22 general principle, people should be referred to what is

1 safe and effective, and I think we all agree with that.

2 What we said later on, is that we should have
3 demonstration projects -- let me finish my response to
4 your two recommendations, which were not on the agenda,
5 and we were tracking here in a different sequence -- is
6 that we were talking about access and delivery in an
7 integrated delivery system.

8 There is a way of establishing that. Those
9 practitioners that are working in an emergency room, as
10 well intentioned as they might be, have no idea what is
11 out there. They don't know what the resources are in the
12 community. They are not well educated.

13 So we are saying, let's find the integrated
14 delivery systems like what we saw in Washington State,
15 and try to have RFPs so that other places can replicate
16 that. We can learn from that experience and then
17 actually concretize what you hope for. You and I have
18 the same, I think, hope, but my point is that by saying
19 it, it isn't so.

20 We are trying to set up demonstration projects
21 so we can get along that trajectory and actually provide
22 improved access and more integrated health care.

1 MS. LARSON: Joseph?

2 MR. PIZZORNO: This is a rich conversation, and
3 I like the intent that Jim states, and Tieraona, I think,
4 is right on, that this is something we can't do now, but
5 I am also thinking about the issues we addressed on the
6 Education Committee, and it is actually bi-directional.
7 Just as we are saying we would like conventional
8 practitioners to refer to CAM when appropriate, we also
9 want CAM practitioners to refer to convention when
10 appropriate.

11 So I am wondering if there is some language we
12 can ask the committee to come up with that makes that
13 kind of statement, and say, that is the ideal. It is
14 going to take time to get there, but that is the ideal
15 for best appropriate access to the most appropriate care.

16 MS. CHANG: In response to that, let me
17 suggest, in lieu of what Jim has proposed, that this
18 recommendation could maybe address all of it: "The
19 Commission recommends that access to affordable, safe,
20 and effective CAM services be better facilitated for all
21 Americans."

22 Then after that, we can go into, both in the

1 text and in operational recommendations, how we would do
2 that. Does that work?

3 That is, by the way, one of the overreaching
4 recommendations that the staff put together for your
5 consideration in the document you got yesterday.

6 MS. LARSON: Do you have specific comments,
7 Tom, on that one?

8 [No response.]

9 MS. LARSON: Does everybody have a copy of that
10 document?

11 PARTICIPANT: [Inaudible.]

12 MS. LARSON: Yes. Michele is going to read Joe
13 Pizzorno's new recommendation.

14 MS. CHANG: So, having started our first
15 recommendation off with that more overreaching one, it
16 would follow that: "In order for the public to have safe
17 and effective access to qualified CAM practitioners, the
18 Commission recommends that such practitioners be
19 regulated, using a standardized and understandable
20 framework that includes licensure and registration, and
21 is accountable to the public."

22 DR. GORDON: That is not instead of No. 52,

1 that is additional. Is that right?

2 MR. PIZZORNO: Let me add, I would actually
3 merge 52 through 57 into one recommendation, and in the
4 text. So I would start with that, and then merge these
5 two together.

6 DR. GORDON: But, Joe, can we use the numbers
7 in the book?

8 MR. PIZZORNO: Nos. 1 through 6.

9 MS. CHANG: What gets complicated here is that
10 what you are all suggesting are really more overarching
11 recommendations, and the ones that we have put into the
12 text are more, if you will, action items or operational,
13 so we still have to go through them.

14 DR. FINS: I think that what Joe wrote was
15 good, and now if we can take the model of our specific
16 recommendations as action items -- and I think this is
17 really kind of an implicit endorsement of what Steve and
18 the staff did, as far as putting in the overreaching
19 comments, because a lot of this is cross-cutting.

20 So, can we hear that again, as an overreaching?
21 And then these will be action items or sub-
22 recommendations, or whatever.

1 MS. CHANG: "In order for the public to have
2 safe and effective access to qualified CAM practitioners,
3 the Commission recommends that such practitioners be
4 regulated, using a standardized and understandable
5 framework that includes licensure and registration, and
6 is accountable to the public."

7 DR. GORDON: I thought you had four items,
8 mandatory license, or title licensure --

9 MS. CHANG: Well, the two kinds of licensure,
10 and then there is the registration, and then there is
11 exemption.

12 DR. GORDON: Maybe those could be put in. I
13 would feel more comfortable that way, as it was in the
14 original recommendation.

15 DR. WARREN: When you start talking about the
16 four levels of regulation by the state, start with the
17 least, because I think licensure is the most extreme. I
18 really don't prefer licensure for CAM practitioners, but
19 it seems to be an insurance pay thing.

20 DR. FINS: Does anybody feel uncomfortable with
21 the way it is written, in the sense that it sounds like
22 it is being federalized? Because we really don't want to

1 communicate that.

2 DR. GORDON: Let's read it again, because it is
3 so important.

4 MS. CHANG: "In order for the public to have
5 safe and effective access to qualified CAM practitioners,
6 the Commission recommends that such practitioners be
7 regulated, using a standardized and understandable
8 framework that includes registration, the two types of
9 licensure, and is accountable to the public."

10 DR. WARREN: How does it impact mom and pop?

11 DR. FINS: This is the level of micro-
12 management. We saw a little bit of this with the DSHEA
13 discussion. What we are saying, as the way to actualize
14 this aspiration of the Commission, is that this national
15 body would help to flesh out the benefits and burdens of
16 various degrees of regulation. They would answer that
17 question.

18 We are simply saying that we are in favor of
19 some kind of regulation, but it is going to be determined
20 on a case-by-case and state-by-state basis about, where
21 do you draw the line and who gets put in which category.
22 Some folks might be exempt, others may be fully licensed.

1 The simple point is, do we agree on regulation,
2 not to say specifically who gets regulated how.

3 Okay, so that is accepted. Any dissent?

4 [No response.]

5 DR. FINS: All right, so let's move on to the
6 first specific recommendation, which now, is put in the
7 context as a way of achieving that.

8 MR. PIZZORNO: So this is No. 1. That's what I
9 just said. Now we are going to talk about each of these
10 as ways of doing it?

11 DR. FINS: Right.

12 MR. PIZZORNO: Okay, so as we go through, we
13 can read them all, but I think that they could all be
14 merged into one, which just says we are going to create
15 this body and it is going to do X, Y, and Z, and just do
16 it as one recommendation.

17 DR. FINS: Let's say that, "The Commission
18 recommends that after a period of time" -- you think six
19 months is enough time? Yes, okay. I agree with that
20 here. "The Commission recommends," full name of the
21 Commission, "that the Secretary," blah-blah-blah,
22 "establish a national policy advisory board, which will"

1 -- it is really Recommendation No. 2 -- "develop and
2 publish" -- develop, not necessarily publish, because it
3 seems too high on -- "develop a consensus on national
4 standards for the practice of CAM that these standards
5 will establish, and that the states could then use to
6 effect local regulations," or something like that. I
7 mean, it is not wordsmithed.

8 Jim?

9 DR. GORDON: I really want to air some of the
10 questions. Let's look at naturopathic medicine. If
11 there are people who are practicing who are licensed
12 naturopathic physicians who graduated from schools, that
13 is one area. Then there are people who are just kind of
14 giving out advice about baths or about diet in a kind of
15 informal way for which they may or may not be paid.

16 I think standards are appropriate in certain
17 instances. I am not sure they are appropriate everywhere
18 and this comes back to the issue that you raised
19 originally, how do we preserve the emergence of new
20 professions, popular healing within this once we talk
21 about minimum educational, ethical, and practice
22 guidelines? So I am concerned about it and I don't know

1 that we are leaving enough latitude when we do that.

2 DR. FINS: First of all, we are setting up a
3 mechanism to answer precisely those kinds of questions,
4 so I think that this body would have a focus group on
5 naturopathy, since you used that example, the full range
6 of people who graduated and maybe did a residency all the
7 way to the other side of the spectrum of somebody who did
8 a home study course in naturopathy.

9 They would hopefully develop a consensus on the
10 recommendations, with the assistance of this body, that
11 would publish some expectations, and then every state
12 would still have the prerogative of setting the standard.
13 We are not going to set the standard. We can't set the
14 standard. We are a federal agency and we are not the
15 states.

16 DR. GORDON: Can I read you an alternative
17 version, just to give you another perspective on it? I
18 am sort of taking one step back from where you have
19 gotten to.

20 I would say: "The Commission recommends that
21 the Secretary of HHS together with the Central Federal
22 CAM Office convene a national policy advisory board,"

1 paren, "including representation of the public and state
2 and local governments as well as CAM and conventional
3 health professionals," close paren, "to address issues
4 related to the licensing and certification of CAM
5 professions, including whether or not national guidelines
6 for CAM licenses," and that is vague, "are appropriate,
7 and if so, in which circumstances."

8 DR. FINS: Tieraona?

9 DR. LOW DOG: I liked it until you got to the
10 very end. I liked "all convening" and all of that.

11 I am just going to go cut and not be
12 politically correct at this moment. When I go get my
13 nails done they have to have a license to cut my
14 fingernails and it is a group where I go of all
15 Vietnamese men and women and they have all gone through
16 and they got their license so that they know how to clean
17 the scissors and clean the manicures and there are
18 potential blood products.

19 When I take my kids to the barber shop, some
20 states require if you shampoo the hair sometimes you have
21 to be licensed to actually shampoo somebody's hair, but
22 certainly if you are cutting somebody's hair you have to

1 have training and licensure.

2 I think that we sometimes pussyfoot around a
3 little bit around the reality that we are making often
4 recommendations about how you should eat, what herbs you
5 should take, what dietary supplements you should have, if
6 you should quit taking your drugs and medication. There
7 is a lot of this going on and I think that minimal
8 requirements are what addresses the public safety.

9 I don't think that means licensure for
10 everything. I think that minimal standards are essential
11 and are important and I think that the Commission needs
12 to have that statement. And I don't think it says
13 licensure, I just think that minimum requirements are
14 essential.

15 If I have a plumber come to my home, I am
16 assured that he is licensed. So why is health care
17 somehow different?

18 DR. GORDON: I mean I would like to hear
19 discussion, and if that is the case, if everyone is at
20 that place, that is okay. I can live with it. I am just
21 raising the issue.

22 DR. FINS: Effie?

1 DR. CHOW: Hi. I like what Jim said to the end
2 statement. I like it to the end statement because he is
3 saying for the group to decide what needs to be regulated
4 and what doesn't. I go back to the self-care, self-help,
5 and other people helping other people, how is that
6 humongous group going to be taken into that, and really
7 suppressing the most important aspect of CAM.

8 I am for regulation, but when it is carried to
9 extreme and you say everybody has to have minimal
10 regulations, there is a big problem there.

11 DR. TIAN: Yes. Regarding Recommendation No.
12 2, I don't like this word "minimum," because you mention
13 that minimum educational, ethical, and practice. This is
14 something wrong, because you put CAM practitioners third-
15 class. I am talking about this page. Have you got my
16 point?

17 So if it is ethical, it has to do to both,
18 either conventional practitioner or CAM practitioner,
19 same standard. Educational, you don't have to mention
20 this word. Just educational or ethical, because we can't
21 have a double standard.

22 DR. FINS: See, we have a conflict on the

1 table. We have Ming arguing for excellence, the highest
2 standards, then we have a more laissez-faire argument
3 saying we don't want to regulate people.

4 DR. GORDON: No, I am not saying that. I am
5 not saying we don't want to regulate. I am saying that
6 we don't know, based on our deliberations, who we want to
7 regulate and who we don't.

8 DR. FINS: Let me make it very clear. We are
9 not going to decide that here. We agree as a body here
10 on the overreaching principle that we were in favor of
11 regulation.

12 The next action item here was whether or not
13 this central body in CAM Central should play a role in
14 facilitating this discussion, which is immensely
15 complicated. It is going to be situational to each
16 individual professional, and context, and what they are
17 doing. It is a tremendous amount of effort, which was
18 beyond the scope of our charge.

19 All we are saying is, should we recommend that
20 this body exist to have these discussions.

21 Joe?

22 MR. PIZZORNO: This conversation is disturbing

1 in a lot of ways. We all agree we need to have
2 regulation. I think we also all agree that we want to
3 have regulation that is appropriate. There are some
4 groups that don't need regulation, there are other groups
5 that do need regulation.

6 Clearly, in areas where we have greater
7 potential risk to the public and where we have
8 practitioners who are trained at a high level we must
9 have licensure because otherwise the public does not have
10 access to them. That access is not public because of
11 lack of legal authority, and also, there is not access
12 because of things like insurance coverage.

13 Why are we having problems with it? It's
14 pretty obvious.

15 So I stick with my statement the way it was,
16 and now I would like to hear some modifications from Jim
17 that may be appropriate but we need to be supportive of
18 licensure where it is appropriate and registration where
19 it is appropriate and if laissez-faire is appropriate
20 some places, that's fine, too.

21 We have heard a lot of testimony here, and the
22 testimony is pretty clear. If you have licensure, you

1 have more safety.

2 DR. FINS: Maybe it is simply enough to say we
3 are in favor of regulation and not micro manage how it
4 gets actualized. I mean, do we not have this central
5 body address it? I think it is kind of a logical place.
6 It may end up happening there but maybe we don't have to
7 go that far. Any thoughts on that?

8 DR. LOW DOG: Jim, could you just reread your
9 recommendation? Because I liked it until the very end.

10 DR. GORDON: Okay, I will read it, but let me
11 just say, Joe, that I would agree with you in some areas,
12 and not in others. For example, the issue of national
13 standards. We heard a lot of conflicting testimony.
14 Some people said yes, many people said no as well. So
15 that is not as clear.

16 MR. PIZZORNO: The established professions were
17 consistent about national standards.

18 DR. GORDON: I'm sorry, what?

19 MR. PIZZORNO: The established professions were
20 consistent about the importance of national standards.

21 DR. GORDON: No, they weren't.

22 MR. PIZZORNO: Yes, they were.

1 DR. GORDON: Acupuncture, Chinese medicine was
2 not, for example.

3 MR. PIZZORNO: I didn't hear that from them.

4 DR. GORDON: Yes. Those were the folks who
5 wouldn't go out to dinner with Joe.

6 MR. PIZZORNO: Well, that was a disagreement.

7 DR. GORDON: Acupuncturists.

8 MR. PIZZORNO: That was a disagreement between
9 M.D.s who were doing acupuncture and the acupuncturists,
10 okay.

11 DR. GORDON: I understand. I am just saying,
12 it is not as consistent across the board.

13 Let me read the recommendation. I don't know
14 that we are that far apart, either. Joe and I talked
15 about this earlier. I feel we have got to grapple with
16 these things, and once we are clear where we are, then
17 the recommendations will follow.

18 I will read mine again. It is: "The
19 Commissions recommends that the Secretary of HHS,
20 together with the Central Federal CAM Office, convene a
21 national policy advisory board," paren, "including
22 representation of the public and state and local

1 governments as well as CAM and conventional health
2 professionals," close paren, "to address issues related
3 to the licensing and certification of CAM professions,
4 including whether or not national guidelines for CAM
5 licensure are appropriate, and if so, in which
6 circumstances."

7 MR. PIZZORNO: I don't like it. Sorry.

8 MS. LARSON: I think it is very, very important
9 that we are very strong in saying, yes, we recognize that
10 groups have such standards, and your wording at the end
11 actually makes it a little bit mushy to me.

12 DR. LOW DOG: I liked it where you got to
13 "licensure and regulation," or whatever. Even Minnesota,
14 which is a more loose model, is still regulated. They
15 just went about their own way of doing it, but it is
16 still regulated because they saw the attempt for
17 regulation, or that there was a necessary step.

18 So I would support your recommendation, but not
19 the end part. I would leave it at "licensure and
20 certification," or whatever, that you put.

21 DR. GORDON: What I was saying was not
22 referring to regulation. I was getting back to your

1 recommendation, but, I think, trying to make it clearer
2 that we are not talking about licensing in every
3 situation, "whether or not national guidelines for CAM
4 licensure are appropriate, and if so, in which
5 circumstances."

6 DR. FINS: Yes, but in our framework that we
7 laid out initially, registration is maybe the minimum.
8 There is also exemption.

9 MR. PIZZORNO: Actually, let's do both. Let's
10 do mine first, and do yours second.

11 DR. FINS: That is the overreaching, which we
12 agreed to, okay.

13 MR. PIZZORNO: But mine says we believe
14 regulation is a good idea.

15 DR. FINS: Right.

16 MR. PIZZORNO: Okay, and then Jim's is saying
17 about how to go about doing this national standard.

18 DR. FINS: If you use the word "modify" where
19 you had your licensure and regulation, or whatever, maybe
20 "the degree of" or "the appropriate level of" versus
21 dictating. The point here is that this body is going to
22 help draw the lines, and we don't know where the lines

1 are.

2 I would agree there probably are some times
3 when there is no need for anything, and there are other
4 times where there is going to be a compelling need for
5 licensure.

6 DR. GORDON: But we are in agreement.

7 DR. CHOW: That is what Jim's thing is saying,
8 whether it is needed or not, and you are just confirming.

9 DR. FINS: We agree, but the way this reads, it
10 sounds like it is less necessary than it is.

11 I think we have agreement. Why don't you read
12 it, and maybe you can say the --

13 DR. GORDON: Okay, let me read it again: "The
14 Commission recommends that the Secretary of HHS together
15 with the Central Federal CAM Office convene a national
16 policy advisory board," paren, "including representation
17 of the public and state and local governments as well as
18 CAM and conventional health professionals," close paren,
19 "to address issues related to the licensing and
20 certification of CAM professions, including whether or
21 not" -- this is just something I wrote. It is certainly
22 not complete -- "including whether or not national

1 guidelines for CAM licenses are appropriate, and if so,
2 in which circumstances."

3 DR. FINS: Two issues. Let's take the first
4 part. You say "licensure," and we simply said, "as
5 indicated by scope of practice," or something like that.

6 MR. PIZZORNO: Again, I want to suggest doing
7 my recommendation first, and doing Jim's second. I also
8 support Jim's without the last sentence.

9 DR. GORDON: Again, Joe and I talked about some
10 of this earlier. We are down the road when we talk about
11 developing uniform scopes of practice. That is down the
12 road from where I think the advisory board needs to start
13 out. We may need uniform scopes of practice, we may not.
14 I don't think we should make that decision at this point.
15 That is my issue.

16 DR. FINS: Suppose we use language of
17 "determining the indication for and feasibility of"?

18 DR. GORDON: I think we need to state the
19 problems and I think it needs to remain an open question
20 as to the degree. We know regulation is necessary. What
21 is the degree? It is going to be different in different
22 circumstances.

1 We heard a lot testimony, Reiki people, other
2 people. They don't want those regulations. I think we
3 need to respect some of these emerging practices, which
4 don't have high risk for danger where people are
5 providing services, some of the self-help groups that
6 feel they should not be included here.

7 I think we need to make it clear that we are
8 not rushing in to create a national standard for
9 everybody and to regulate them. That is the feeling,
10 tone, and there are some specifics in the
11 recommendations, a couple of which I pointed out, that
12 bring that across. So that is what I am looking for.

13 DR. FINS: Michele?

14 MS. CHANG: The first is, "In order for the
15 public to have safe and effective access to qualified CAM
16 practitioners, the Commission recommends that such
17 practitioners be regulated, using a standardized and
18 understandable framework that includes registration,
19 title licensing, mandatory licensing, and is accountable
20 to the public."

21 DR. GORDON: You also had an exemption in
22 there, too.

1 MS. CHANG: "Exemption and is accountable to
2 the public," followed by: "The Commission recommends
3 that the Secretary of HHS together with the Central
4 Federal CAM Office convene a national policy advisory
5 board," paren, "including representation of the public
6 and state and local governments, as well as CAM and
7 conventional health professionals," close paren, "to
8 address issues related to the licensing and certification
9 of CAM professions, including whether or not national
10 guidelines for CAM licenses are appropriate, and if so,
11 in which circumstances."

12 DR. FINS: How about something like the
13 language of "whether there is a role for"? How is that?
14 I mean, "whether there is a role for," which doesn't say
15 that it is necessary or not necessary, but whether or not
16 there should be a role, whether there is a role for
17 national standards. Does that work?

18 MS. CHANG: So then it would be, "to address
19 issues related to the licensing and certification of CAM
20 professions" --

21 DR. FINS: "And whether or not there is a role
22 for national standards."

1 MS. CHANG: "A role for national guidelines for
2 CAM licenses."

3 DR. FINS: "Practitioners." Not licenses but
4 CAM practitioners.

5 Tom?

6 MR. CHAPPELL: I remember months ago we were
7 also in this context speaking about transferring the
8 learnings from those professions that had done a good job
9 on self-regulation and self-development to those
10 professional groups that were not as far along in their
11 evolution.

12 So I mean we as a national group or national
13 office could facilitate that kind of transfer of
14 knowledge and learning and that that is different from
15 trying to, certainly, adopt national standards. So I
16 want to be sure we are not reaching out here beyond what
17 we didn't want to do months ago in this regard and there
18 is a facilitative training role that a national body
19 could play here rather than an authoritative one.

20 DR. FINS: Tom, I think that is a great
21 suggestion and certainly the intention, I think, that
22 this body would provide technical assistance in a

1 clearinghouse function and maybe that would follow as the
2 next recommendation.

3 Michele?

4 MS. CHANG: Could I just suggest, because we
5 had said that what we might want to do since we have this
6 overarching recommendation but do another overarching
7 recommendation about establishing a national advisory
8 policy board to do X, Y, and Z.

9 So if we could go ahead with the overarching
10 recommendation, and then say we want to establish a
11 national policy advisory board to provide technical
12 assistance and develop policy guidelines on issues
13 related to the access and delivery of CAM, including,
14 Point 1, "issues related to licensing and certification
15 of CAM professionals, including whether there is a role
16 for national guidelines for CAM practitioners"; Point 2,
17 we haven't gotten there yet.

18 What we would do is technical assistance action
19 items, as well as policy ones like the one we just said.

20 DR. FINS: Point 2 would be, "facilitate
21 exchange between the emerging professions to optimize the
22 evolution of their development."

1 DR. GORDON: I want to come back to Joe's
2 point, too. I think where there is a strong feeling the
3 professions want licensure, we should support that. I
4 feel that that needs to be stated as well, and I think
5 this is very much of a pluralistic approach, so we are in
6 agreement. I just want to leave the field open, and also
7 make it possible for these professions that have matured
8 to come into their own.

9 DR. FINS: Then maybe the next bullet item on
10 that list that Tom has started us on is something about,
11 "provide advice and guidance" -- but again, I don't want
12 to be too strong -- "to states, as they develop their own
13 standards for regulation and oversight of CAM
14 practitioners and conventional providers," providing CAM
15 services, in other words.

16 DR. GORDON: That is one piece. The other is
17 helping the professions, which comes back to what Tom was
18 saying, helping the professions to define themselves.

19 DR. FINS: We could have spent the last two
20 years talking about the regulation of naturopathy and
21 spent just as much time on that one single item.

22 As I envision this Central Office, is that they

1 could have subcommittees working on various professions
2 as they are emerging, and hopefully there would be cross-
3 pollination and they would be able to talk with each
4 other. Professions that were two steps ahead could share
5 their insights and their evolution.

6 So I think we are all getting on the same page
7 here. We have lost half of the group. These guys have
8 defected to the next commission.

9 MS. LARSON: Joe, can I ask you a question?
10 You wanted to collapse them into one. Would it be
11 sufficient to cover the overarching recommendation and
12 have those others as action items?

13 MR. PIZZORNO: Well, I think the second
14 recommendation that was Jim's language, I think we could
15 collapse. Nos. 1, 2, 3, 4, 5, and 6, could all be
16 collapsed under that one, yes, as action items under that
17 one.

18 MS. LARSON: Do we have consensus on what was
19 just put forth by Joe Pizzorno, this is sent back to us
20 with the purpose of condensing Recommendations 1 through
21 6 into specific action items under an overarching
22 recommendation?

1 DR. GORDON: Yes, as long as they conform in
2 spirit and content to those overarching recommendations.

3 MS. LARSON: Nos. 1 through 6.

4 [No response.]

5 MS. LARSON: Consensus. We will get back to
6 you.

7 DR. FINS: Now, we have a 7 and a 7(a), which,
8 7, basically, now is directed to the states. We are
9 encouraging them to work closely with this advisory body,
10 so we are going to offer them services in the previous
11 cluster of recommendations, and now we are asking them to
12 work closely with HHS's advisory body through the Central
13 Office to develop standard operational guidelines for the
14 regulation oversight of licensed physicians practicing
15 CAM.

16 Now, I think we should probably stop it there
17 and leave, "which are based on national uniform scopes of
18 practice," because we decided that was overreaching. We
19 never really meant to say that.

20 Michele, please?

21 MS. CHANG: Yes. I just want to give a
22 background point on this. If you read the text, which I

1 am sure you did, the Federation of State and Medical
2 Boards will be putting out draft recommendations. Gerri
3 talked about that, or you all talked about it, in
4 Research. The difficulty that we saw is that they are
5 somewhat broad, they don't provide some operational
6 guidance to states that would really take them to the
7 next step.

8 So what is being suggested here is that this
9 national board, or whatever, take that next step to help
10 to work with FSMB and state regulatory boards to make it
11 a little clearer to states and more helpful to
12 practitioners how to go about accomplishing the spirit of
13 the draft guidelines of the FSMB which, by the way, have
14 not yet been promulgated.

15 DR. FINS: I think it is important to just
16 point out that we are really trying to provide a parody
17 structure through this national office that the FSMB has
18 for allopathic practice.

19 In other words, each state has its own medical
20 board but then they come together and in a way form
21 national policy through a national standard. What we are
22 saying here is this body will try to do the same thing on

1 the CAM side and have a national collaboration and also
2 with each individual state.

3 Wayne?

4 DR. JONAS: Yes, I want to suggest that in
5 terms of prioritizing which groups this board would work
6 with, I think it would be better to work with the state
7 legislators first and then the state medical boards
8 second, because state medical boards generally have a
9 fairly narrow scope around medical practice. This is
10 obviously broader than that, and that is under the
11 jurisdiction of the state legislative branches.

12 MS. LARSON: So, would you put in state
13 legislatures?

14 DR. JONAS: Yes. I would put state legislators
15 first, actually.

16 DR. GORDON: Okay, great. Effie?

17 DR. CHOW: It is the view of the medical
18 acupuncturists and the traditional acupuncturists that we
19 should prevent something like that happening in all the
20 other fields of practice, and that consultation with
21 respective professional CAM practices should be included
22 in making recommendations as to the adequacy of training

1 for the medical physician to practice CAM. I think that
2 is really essential.

3 DR. FINS: I think this is where the cross-
4 cutting recommendations are going to play out because
5 some of that will be in the education, and some of it is
6 in the constitution of these boards. So I think you are
7 absolutely right.

8 DR. GORDON: I have two comments. One is, I
9 don't think we should get to that level of specificity
10 there, and number two, I think it is important that this
11 apply not just to medical boards but to the boards of
12 conventional practitioners generally, because, remember,
13 we heard from the nurses about their concerns about these
14 very same issues.

15 DR. FINS: Can we, Michele, just broaden it to
16 other allopathic practitioners?

17 DR. GORDON: The issue that you mentioned is
18 one of the hottest of all issues -- and I don't think we
19 should try to push it -- not just with acupuncture but
20 with chiropractors and massage therapists, and all
21 different kinds of groups. I think we really need to not
22 make any premature foreclosures here.

1 DR. CHOW: Oh, no. I am just speaking in-house
2 here. That is not to be put into the recommendation.

3 DR. GORDON: Okay.

4 DR. CHOW: It is just so that we know that
5 problems have arisen already.

6 DR. FINS: All right. I have reached closure
7 on 7, and want to go now to 7(a), which is related. I
8 don't think we will have trouble with it because we
9 agreed to this yesterday. It's a new one and I don't
10 think --

11 MS. LARSON: It's on your sheet.

12 DR. FINS: I don't think they have it on that.
13 Do they have that?

14 MS. LARSON: "Insert new recommendation."

15 DR. FINS: Oh.

16 MS. LARSON: Here it is.

17 DR. FINS: Okay, good. I didn't have it.

18 So it is, basically: "The Commission
19 recommends that CAM practitioners, or conventional
20 practitioners who use CAM products" -- I can't read my
21 own writing here. "The Commission recommends that CAM
22 and conventional practitioners who use CAM services and

1 interventions in IRB-approved research not be sanctioned
2 by state regulatory boards solely for the use of such
3 approaches."

4 We agreed to it, but this is written from the
5 other side, that the board should not sanction the
6 practitioner if he has had IRB approval. Before it was
7 the other way around. It is the mirror image.

8 So, all in favor? We all agree?

9 [No response.]

10 DR. FINS: Okay. We are now moving up the food
11 chain a little bit from the practitioner question to,
12 more, organizations of care.

13 Recommendation No. 8. We are hopefully going
14 to meet or have some more discussions with the joint
15 commission, but if you give us your proxy, as it were, we
16 will work on this.

17 The idea here is: "The Commission recommends
18 that nationally recognized accrediting bodies assume
19 leadership roles to review the most commonly used and
20 evidence-based CAM modalities in their health care
21 organizations, especially those with particular relevance
22 to a coordinated care approach with respect to

1 establishing accreditation standards."

2 In my view, this speaks directly to Jim's
3 initial plea. It is a way of operationalizing what he
4 said for integration, and what we are trying to do here
5 is get the hospitals and the joint commission to think
6 about what kind of expectations will they require of
7 their member bodies.

8 Again, joint commission accreditation is often
9 a proxy for state certification of the health care
10 institution. So if we can get the joint commission to
11 say there should be educational materials as part of
12 patient/family education, which is a requirement on CAM,
13 if there should be a relationship to CAM services in the
14 community, et cetera, that is a way to help
15 operationalize Jim's, I think, well-argued plea at the
16 beginning to provide more access.

17 DR. GORDON: Just a question here. Are we
18 talking about credentialing practitioners, or accrediting
19 institutions?

20 DR. FINS: Institutions. Really, institutions
21 that currently fall under the purview of the joint
22 commission. Any of you who have gone through our joint

1 commission accreditation survey know that everything from
2 soup to nuts gets addressed, and policies get rewritten.

3 To effectuate change in complex health care
4 settings is through this really comprehensive approach
5 the joint commission has.

6 DR. GORDON: So when you say "nationally
7 recognized accrediting bodies," you are speaking of JACO
8 and others?

9 DR. FINS: Among others.

10 DR. GORDON: Okay, but you are not speaking of
11 the massage therapists, you are speaking about bodies
12 that are credentialing institutions. I just think that
13 may need to be clearer in the recommendation.

14 DR. FINS: It is in the text. We are talking
15 about facilities. We can tweak that, but just so it
16 jives with the text.

17 MR. PIZZORNO: I don't get it. I don't see why
18 we are doing No. 8, so would you try again? I heard you
19 talk, but I don't see any reason for No. 8.

20 DR. FINS: Do you spend any time in allopathic
21 hospitals? I mean, administratively in any way,
22 community hospitals?

1 MR. PIZZORNO: No.

2 DR. FINS: I do, and for example, a few years
3 ago they said pain has to be the fifth vital sign, and
4 every hospital has to ask patients on a scale whether
5 they are in pain or not. Well, now every hospital in
6 America has an analog visual scale, and when you get your
7 blood pressure taken, the nurse or the practitioner is
8 supposed to ask you whether or not you are in pain. It
9 has revolutionized pain assessment.

10 Is it everything that needs to be done? No.
11 Is it a step in the right direction? Absolutely.

12 So these guys, they have a book full of
13 standards, on how the refrigerators work all the way to
14 how ethics committees or ethics processes should be
15 developed. They have a section on patient/family
16 education, for example. If they were to include
17 education on CAM as one of their requirements and
18 standards, a hospital would get surveyed every three
19 years by a team of surveyors, they look at everything,
20 and they would say, show me your patient/family education
21 on CAM or referrals.

22 And so, what we want them to do is to develop

1 an incremental approach with the spirit of this
2 commission informing that through those discussions that
3 are yet to be had, and other bodies to do that.

4 Trust me on this one, Joe.

5 DR. GORDON: Joe, I think the thing here is,
6 that from my point of view -- I'm sorry, do you want to
7 say something?

8 MR. PIZZORNO: Actually, I better understand,
9 and so I would then make a modification to it. At the
10 end of the second line where it says, "evidence-based CAM
11 modalities," I would probably put in there,
12 "practitioners and therapies." Look at St. John's wort.
13 It is also who is in the community.

14 DR. GORDON: The addition I would like in
15 there, Joe, is some of that context, that this is for the
16 purpose of including these in the institution.

17 DR. FINS: It is in the text, but another
18 example we could flesh out would be how would a hospital
19 formulary integrate supplements into their mix?

20 DR. GORDON: All I am saying is that we need to
21 understand the direction that this recommendation is
22 moving in.

1 DR. FINS: Are you all in favor of the spirit
2 and the intent of the recommendation regulation, No. 8?

3 [No response.]

4 DR. GORDON: Okay. "The Commission recommends
5 that nationally recognized accredited bodies assume
6 leadership roles to review the most commonly used and
7 evidence-based CAM modalities, practitioners, and
8 therapies, especially those with particular relevance to
9 coordinated care approaches with respect to establishing
10 accreditation standards."

11 We will tweak. We will tweak, we will get it
12 back to you.

13 DR. GORDON: Yes. What I want to say is --

14 DR. FINS: I think we all want the same thing.

15 DR. GORDON: Right. There are a number of
16 these recommendations for which we know the direction we
17 are headed, but essentially we are sending them back to
18 you all for the tweaking. So I would like those to come
19 back to the group.

20 DR. FINS: But this is a minor tweak. On all
21 the tweaks we had to do, this one is a minor one.

22 Veronica?

1 MS. GUTIERREZ: I would just like to make sure
2 that we clarify in the statement after "accrediting
3 bodies" we insert "for institutions," just to clarify.

4 DR. FINS: Right, right. Okay.

5 Conchita?

6 DR. PAZ: Well, one of the things with the
7 institutions is that they are not always in one
8 particular location. They may have satellites that are
9 part of that institution.

10 DR. FINS: The joint commission, for example,
11 when they accredit hospitals, and their satellite clinics
12 go out and visit those clinics.

13 Effie?

14 DR. CHOW: You will spell out "nationally
15 recognized conventional accrediting bodies"? That is
16 what we were talking about. There was a question about
17 not a massage therapist. "Conventional accrediting
18 bodies."

19 DR. FINS: "Conventional," you're right.

20 DR. CHOW: Then also, again, I would add "with
21 consultation on CAM experts to determine the integration
22 of."

1 DR. FINS: Yes. It refers to the text. We
2 will just bring it down, but basically establishing
3 accreditation standards in consultation with the usual
4 suspects.

5 So we are now moving on to coordinated delivery
6 systems. Again, we are moving from this sequence here,
7 from the office-based doc, the practitioner, rather, to
8 the clinic or the hospital, to now more integrated
9 delivery systems.

10 What we recommended on page 28, rather, is
11 again, to really flesh out the question that Jim raised
12 at the outset. This could be, depending on how we
13 organize this, a subset of that one, basically saying,
14 look, we don't know how to do this all that well, and the
15 bodies that we are talking about should fund and support
16 efforts by the designated Federal Office on CAM to
17 collaborate with private sector studies and demonstration
18 projects that evaluate the usefulness, effectiveness, and
19 cost benefits of collaborative care models at three
20 delivery levels.

21 The three levels are office-based, freestanding
22 CAM-type clinics like the Steer Clinic or Wellspace, and

1 then into vertically integrated, primarily allopathic
2 delivery systems. So there are three at three levels,
3 okay?

4 There are things that can be learned from what
5 is going on, say, in studying the Bastyr Outpatient
6 Clinic and the Bastyr Medical School and its relationship
7 to other care systems in the Seattle area, and we need to
8 study that more so we can replicate it, and so it won't
9 require charismatic leadership to happen. Anywhere it
10 could happen, right, Joe?

11 DR. GORDON: I would like to add that the
12 federal government make available information that is
13 already available about these programs, that that be part
14 of it as well as look at more demonstrations because if
15 that information is available, then while the federal
16 government is doing its own thing other people will be
17 able to cite that information and move it ahead.

18 DR. FINS: Okay. Good point. Don?

19 DR. WARREN: I think this recommendation is
20 okay. I think we need to accept it and move on.

21 DR. FINS: Thank you. Any dissent on that
22 issue?

1 DR. GORDON: You are adjusting both No. 9 and
2 No. 10? Because there are two recommendations here. We
3 have gone from 9 onto 10, right?

4 DR. FINS: Oh, I'm sorry. I skipped No. 9. So
5 we did No. 10, okay. So we have just approved No. 10.

6 No. 9. Okay. Go back to 27, which was on the
7 bottom of the page.

8 This is basically that there should be more
9 epidemiologic studies of CAM patterns of usage with
10 special attention to ethnic and vulnerable populations.
11 To understand what we are dealing with, again, to make
12 the argument for the access argument, if the numbers are
13 huge the entitlement should be great.

14 DR. WARREN: I believe we ought to accept this
15 one, also.

16 DR. FINS: All in favor? Any dissent?

17 [No response.]

18 DR. FINS: Okay. Great.

19 No. 11. Now, these changed. All right. It is
20 on your sheet of paper.

21 "In recognition of the need to promote more
22 integrative models of care delivery, the Commission

1 recommends demonstration projects using hospices as a
2 model to explore means of integrating safe and effective
3 CAM into an allopathic setting." The rationale, this
4 expands upon No. 10 by using a model with a proven track
5 record that shows where integration does occur primarily
6 in an allopathic setting, and this might illustrate and
7 lead to emerging efforts to develop more efficacious
8 service delivery models that could be used in other
9 settings.

10 Joe?

11 MR. PIZZORNO: Could we add community health
12 clinics? We left them out.

13 DR. GORDON: Yes.

14 MR. PIZZORNO: I think they belong right there.

15 DR. FINS: I think those are two places we have
16 heard testimony from where there was good integration,
17 and I think that is good because one is a preventative
18 outpatient and the other is the beginning of when you are
19 well and the other is when you are not. So I think it is
20 a very nice balance there. That is great. And using
21 that as a focal point to study delivery systems.

22 So all in favor of that?

1 DR. GORDON: Let me just think for a second if
2 there is any --

3 DR. FINS: Oh, I'm sorry.

4 DR. GORDON: -- if there is another example
5 that will --

6 DR. FINS: Well, I don't want to dilute the
7 examples too much.

8 DR. GORDON: I understand.

9 MR. CHAPPELL: We are actually just trying to
10 get a sense of prioritization of these, which you will
11 get to, I guess, eventually.

12 DR. FINS: I am told by --

13 DR. GORDON: Let's just let it go and come up
14 with something. I will get it to you.

15 DR. FINS: All right. No. 12 here was what we
16 saw before with the indigenous healing traditions, and
17 did we reach closure on that? It got deleted?

18 DR. GORDON: It got deleted.

19 DR. FINS: Okay. All right.

20 DR. GORDON: They got deleted in favor of
21 looking at the recommendation you were proposing.

22 DR. FINS: Oh, now it is back. Okay.

1 So, here let me read it to you. "Within three
2 years," -- again the time frame is correct -- "the
3 Central Office should report to the Secretary on the use
4 of indigenous healing traditions in the United States to
5 identify commonly used best practices and challenges and
6 potential areas for collaborative learning between such
7 traditions and conventional care. The Commission urges
8 this report to include recommendations for the future as
9 regards appropriate protection of such traditions as well
10 as research and development of such practices as part of
11 community-based health care. Members from such
12 traditions should be involved closely in this endeavor."

13 Joe?

14 MR. PIZZORNO: We ought to want to add a little
15 comment about education just in terms of recommendations,
16 but include education because you transfer that over from
17 education.

18 DR. FINS: Do you have a specific place where
19 you want to put that?

20 MR. PIZZORNO: Yes.

21 DR. FINS: What line?

22 MR. PIZZORNO: "To include recommendations for

1 the future as it regards appropriate education,
2 protection of such traditions," just put this stuff --

3 DR. FINS: Okay. "Regards appropriate
4 education," okay. Good.

5 DR. CHOW: Is there a description as to what
6 the indigenous healing traditions include? Is it just
7 the Native American or what other?

8 DR. FINS: Good point. Are we going to have a
9 glossary in the back of the thing? Yes, so whatever word
10 that we don't define in the text will be defined in the
11 back. But it brings up the question, how expansive do we
12 want this definition to be? Any thoughts? Because there
13 are Hispanic traditional healers, there are Native
14 American healers, there are traditional Chinese
15 medicines.

16 DR. GORDON: I think we need to leave that up
17 to this group. We can't define it right now.

18 DR. CHOW: It needs to be described.

19 DR. FINS: I think for the glossary I would be
20 more expansive in this definition.

21 DR. GORDON: I think there are two things. In
22 the text we can talk about some of the issues, some of

1 the different kinds of traditions that come up, examples.

2 DR. FINS: Okay.

3 DR. GORDON: The other thing I think that is
4 important here that we dropped out of the other section
5 has to do with education.

6 DR. FINS: We added it.

7 DR. GORDON: Oh, and where did we add it?

8 DR. FINS: We said, "as regards appropriate
9 education, protection of such traditions."

10 DR. GORDON: Okay. Fine. Thank you.

11 DR. FINS: Okay? Accept as written?

12 DR. GORDON: Yes.

13 DR. FINS: Okay. Great. All right.

14 DR. GORDON: I have got to go back to No. 11.

15 I think that the most important models that have taken
16 place, the earliest models were in the private and non-
17 profit sector and the people who have been doing this
18 work for many, many years, and I think we need to learn
19 from those models. Collaborations between conventional
20 physicians and CAM providers have gone on for a long time
21 and so I think hospice and community clinics but we also
22 have to say private and non-profit sectors there, too.

1 Because they are just central to this whole issue.

2 DR. FINS: Yes, actually, that works
3 beautifully because it tracks with our hierarchy. We
4 have the individual practitioner, right, which would be
5 what you are referring to. The second tier is the
6 community clinic, and the third tier is something that is
7 integrated in the delivery system. So that tracks
8 beautifully.

9 DR. GORDON: Okay. So we fit in private and
10 non-profit.

11 DR. FINS: Yes.

12 DR. GORDON: All right.

13 DR. FINS: The final recommendation is one that
14 was presented to us, and it is not the product of our
15 working group, but it is one that we were asked to
16 convey.

17 I will just read it to you: "The federal
18 government, including but not limited to the Department
19 of Agriculture and Health and Human Services, should fund
20 and support efforts by the designated Federal Office on
21 CAM to evaluate the feasibility costs versus benefits and
22 overall impact on allowing food stamp program

1 participants to use food stamps to purchase specified
2 single or multivitamin mineral products that do not
3 exceed the nutritional recommendations of the Food and
4 Nutrition Board of the Institute of Medicine."

5 DR. GORDON: Can you speak into the machines,
6 please?

7 DR. LOW DOG: We were talking about safe and
8 effective, and access to them. Don't we have that under
9 Services and Products in one of our earlier
10 recommendations? I mean, here you were specific, but --

11 DR. FINS: This is specific that people could
12 use food stamps to buy supplements.

13 DR. GORDON: Joe, do you want to give a
14 background on this?

15 MR. PIZZORNO: I think Michele will have to
16 give background, because it wasn't the product of our
17 working group.

18 MS. CHANG: I don't know how much background
19 you want. I think, just to make it really quick and
20 fast, there is at this time the possibility of such a
21 program being put through Congress. It is being
22 considered.

1 And so, what this recommendation does is put a
2 little bit of a break on that and say, well, before we go
3 ahead and invest in that program, why don't we do some
4 studies, feasibility and impact studies.

5 The issue at discussion here is not so much
6 whether a feasibility is a good thing to do before you
7 implement a program of this magnitude, but rather, do we
8 conceptually agree that this is a good idea at all.

9 DR. GORDON: I think this is just something we
10 really need to know more about, because we haven't really
11 discussed it. I'm sorry, go ahead.

12 DR. FISHER: I'm embarrassed. I was a chairman
13 of a committee that several years ago recommended to the
14 USDA that they allow food stamp participants to utilize
15 food stamps to buy multivitamin mineral preparations. It
16 was particularly based upon a consensus opinion of a
17 bunch of nutrition scientists and others that this was
18 perfectly logical because they should have the freedom to
19 purchase dietary supplements of a multivitamin and
20 mineral nature, not just across the board.

21 For the reasons which Michele has included on
22 the page after this, USDA turned it down. I won't give

1 you my opinion about what USDA did, but I think you
2 probably could figure that out.

3 Basically, what has happened now, as Michele
4 has indicated, it has been reintroduced into Congress.
5 Quite frankly, it might strengthen what some people would
6 like to be done if, instead of recommending a study, per
7 se, as is in the guidelines, it might be useful to
8 recommend that USDA change its administrative procedures
9 because that is really the only impediment that stands in
10 the way of giving the choice to food stamp participants.

11 There are a lot of other nuances in the
12 background here, but really, suggesting that USDA review
13 or reconsider its administrative procedures will probably
14 get more done than calling for another study.

15 DR. LOW DOG: I think if we are talking about
16 health promotion, wellness and prevention, primary
17 prevention, immunizations is one example, but folate
18 during pregnancy is certainly another, and that if we are
19 talking about access, I don't know how you can support
20 just a plain old multivitamin in food stamps, especially
21 given the population that would benefit from it.

22 DR. GORDON: That would potentially benefit

1 from it.

2 DR. LOW DOG: That would potentially benefit
3 from it.

4 DR. GORDON: So, how would you like to change
5 the wording, Ken or Tieraona, to reflect what Ken has
6 suggested?

7 DR. FISHER: I think we have got some language,
8 I think Michele has, when it got transferred from one
9 section to the other, I think it has already been
10 reviewed.

11 DR. FINS: Let me just suggest, since it is new
12 to everybody and we haven't heard any testimony on this,
13 that we get this information and we make it available for
14 February, we come back, we consider it. If there is
15 additional documentation, that we have that discussion.

16 I think it makes sense in many respects, but it
17 also could be perceived as there are people who are on
18 food stamps and they are going to somehow substitute this
19 because they can't afford their food. I think we just
20 have to be clear about what the intention is.

21 It sounds like you have got a very valid point,
22 and the issue about pregnancy and folic acid is also

1 critical. So, I think it would be premature.

2 DR. GORDON: Do you want to wait until
3 February, or do you want to do it sooner than that? I
4 think we need to do it sooner, Joe.

5 DR. FINS: I think we should do it in 10 days,
6 not right now. Let's get a little more information on
7 the table.

8 DR. GORDON: Okay.

9 DR. FINS: All right.

10 DR. GORDON: We are finished.

11 [Applause.]

12 DR. GORDON: Veronica?

13 MS. GUTIERREZ: I would like to go back to the
14 text. I saved this for last, page 11. I am a little
15 uncomfortable on lines 14 through 16, and I would like to
16 suggest, maybe, some other terminology.

17 It presently reads: "Most licensed CAM
18 practitioners must follow a legal and ethical code to
19 refer the patient to a licensed medical doctor when the
20 patient's clinical condition exceeds the practitioner's
21 scope of competence."

22 This works both ways, and I would like to

1 suggest that it read: "Licensed practitioners must
2 follow a legal and ethical code to refer the patient to
3 another licensed health care provider when the patient's
4 clinical condition exceeds the practitioner's scope of
5 competence or understanding."

6 DR. GORDON: Sounds great.

7 DR. FINS: I think we have agreement to that.
8 Do you have another one?

9 MS. GUTIERREZ: That's it.

10 DR. FINS: Okay, great.

11 DR. GORDON: Great.

12 DR. FINS: Thank you all.

13 DR. GORDON: Thank you, too. You did a
14 fabulous job.

15 Let me just say that in this section we have
16 many recommendations that are either going to be
17 consolidated, significantly tweaked, or tweaked in a
18 minor way. So what we will be looking for is, over the
19 next 10 days, to discuss some of the issues that are
20 still unresolved, and then after the 10 days, another
21 look at the recommendations.

22 Okay? Everybody with me on that?

1 [No response.]

2 DR. GORDON: So we have consensus about general
3 directions. I just want to make this point clear. There
4 are many of these recommendations where we don't have
5 consensus on the exact wording. So we need to see the
6 exact wording in this 10-day period.

7 Yes, Wayne?

8 DR. JONAS: Jim, I think that maybe even more
9 important than consensus on exact wording is going to be
10 prioritization, and I think we really need to address
11 that not just in this area but in the entire field
12 because you are partly trying to do that with the
13 consolidation of these, but as we saw in this particular
14 session, when you go about doing the consolidation what
15 often emerges is actually a new recommendation or an
16 overarching recommendation which really is new.

17 And so, I think the prioritization issue is
18 going to hopefully result in the emergence of overarching
19 recommendations that are going to be different than we
20 have in here. So we really need to get to this and have
21 sufficient time to do that fairly soon.

22 The other thing that is going to come out is,

1 which ones do you want up front? As I look at the list
2 that you have, and I think about what is going to make
3 some impact for the public benefit as opposed to
4 ferreting out different sections for different licensed
5 practitioners, it is No. 10, the demonstration projects
6 in which they look at whole systems -- again, our first
7 principle, holistic approach to care -- and we will
8 actually see, does this help particular populations.

9 So I would put that on the top of the list as a
10 concrete aspect. This is the kind of thing I think we
11 need to address in all of these areas, but this, I think,
12 is fairly clear here, also.

13 DR. FINS: I think, Dean, you are also right,
14 and I think that --

15 PARTICIPANT: Wayne.

16 DR. FINS: Geez.

17 DR. JONAS: Well, I said it for him.

18 [Laughter.]

19 DR. FINS: I'm sorry, Wayne. It is that
20 abduction thing.

21 But what I think is really important, is that
22 the way this thing has evolved, there are certain

1 conceptual sequences. But the way we made sense of it is
2 not how we necessarily have to present it to the public,
3 because micro to macro may be a logical sequence, but
4 it's not necessarily how it's going to be sold.

5 DR. JONAS: What makes me nervous is that I do
6 not see an opportunity right now -- maybe it's planned
7 in, and it just hasn't been discussed -- when this is
8 going to happen for all these different sections and
9 recommendations.

10 DR. GORDON: Steve, want to respond?

11 MR. GROFT: Wayne, you are absolutely correct.
12 We do have to do something like this between now and when
13 the report is even prepared in draft, so we will be
14 working with the groups. Again, the important thing is
15 that everyone has to read what we send out and get back
16 with us in a timely fashion.

17 DR. GORDON: At the end of today, Steve is
18 going to lead a discussion in the process of
19 prioritization. That is all we can do here, is begin
20 that discussion, and then, as Steve is suggesting, a lot
21 of it will have to be within the groups and getting
22 material back to the whole Commission.

1 DR. JONAS: Yes. I suggest in February, though
2 it has to be resolved before that. It has to be resolved
3 before we prepare the final report, and we need some
4 guidelines as to how the various groups are going to go
5 about their prioritization, so that they are not just all
6 over the map, I think.

7 MR. GROFT: We will be doing that next week in
8 our debriefing exercises there.

9 DR. GORDON: Yes. Your point is very well
10 taken.

11 What I want to do now is give everyone an
12 opportunity for proper nutrition. So what we are going
13 to do is, we are going to take 20 minutes without a
14 public meeting, where we will begin the process of
15 eating, and we will just go over a couple of
16 administration issues for ourselves, and then we will
17 start again at 1:15. Don has said that he expects to get
18 through it a little bit more quickly.

19 DR. WARREN: It's going to be about a minute
20 and a half.

21 DR. GORDON: So we should have more time at the
22 end to discuss some of the other issues regarding

1 prioritization.

2 Thank you, Don.

3 [A lunch recess was taken at 12:55 p.m.]

4 + + +

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

[1:50 p.m.]

DR. GORDON: We are going to begin now with Coverage and Reimbursement.

Let me amend that. We are going to talk first about the dates for the February meeting and then we are going to go into Coverage and Reimbursement.

Incidentally, I just want to say again to the commissioners I really appreciate the speed with which everybody is willing to move from one issue and location to another.

Steve?

MR. GROFT: Possible dates. We are still looking at Thursday and Friday, and I think the feeling is anything after the 22nd would be too late. That would be the latest possible date. The 14th and the 15th is a possibility. 21, 22.

DR. GORDON: Is everybody on this now? We need to make a decision. Only the 14th and 15th and 21st and 22nd, Steve, at this point?

MR. GROFT: No. The 18th and 19th but I think some people said they could not be here for the 18th and

1 19th.

2 DR. GORDON: Is that true?

3 MR. GROFT: Are there people who can't be here
4 the 18th and 19th? Could you raise your hand, just so we
5 can see?

6 [Show of hands.]

7 MR. GROFT: Bill Fair.

8 DR. GORDON: Okay, good.

9 MR. GROFT: There is a fair number.

10 DR. GORDON: Twenty-one, 22. Steve, we don't
11 feel that is too late? That would be okay?

12 MR. GROFT: No, I think we are prepared to get
13 it completed by the 7th. Some activities, like the
14 preparation of the final report will be done, just to
15 separate out a couple of things.

16 One is the written document that we normally
17 think of as the report will go forward by the 7th. We
18 will then enter that document in for regular publishing
19 and printing with all the refinements and nice
20 accompaniment that would go with it, any pictures, the
21 graphics, other things that we may want to do,
22 highlighting different parts.

1 That is a printing issue that will continue
2 after the Commission ends because we are not going to
3 print until we get agreement and acceptance of the
4 report.

5 DR. GORDON: Agreement and acceptance from?

6 MR. GROFT: First from here, and then it is
7 cleared and signed off by the Secretary, sending it to
8 the President and to the Congress, because we want to
9 have those letters in as well.

10 DR. GORDON: Steve, are we going to come back
11 and go through the steps from now until the final report
12 in an hour or two, or do you want to that now?

13 MR. GROFT: If you have the hour here, I could
14 easily cover them right before we go into the Public
15 Session.

16 DR. GORDON: Okay.

17 MR. GROFT: Well, do you want to talk about
18 them now? Would that help?

19 DR. GORDON: Well, I think we need to let
20 people know exactly what we are going to be doing in
21 February, and what we are doing between now and February,
22 and then what happens after February.

Final Report: Process

MR. GROFT: Okay. We are going to take the recommendations back that we heard from here and the work groups that have to revise them will revise them and then contact the other folks who have concerns and issues. With that, the writing of the text --

DR. GORDON: The revision of the recommendations will take place over approximately the next 10 days, okay? Everybody clear, perfectly clear on that?

MR. GROFT: We will take those and then we would like to have everything resolved, if there are any questions whatsoever, resolved by January 8th so that the final writing can be undertaken.

DR. GORDON: Any questions on recommendations?

MR. GROFT: Any questions on recommendations, right. Or if there are any problems with any section of the text that you have seen thus far we would like to ask you to send those comments back to us saying, I have got a problem with the way this was expressed or these words. I think Veronica gave us a couple of word changes today that she just felt needed to be done. So, anything like

1 that that you found offensive or not really
2 representative of what you think needs to be expressed.

3 DR. GORDON: Or issues with tone.

4 MR. GROFT: Yes, issues with tone. So there is
5 a lot of writing that has to be done. Jim will be doing
6 some writing and we have someone else to do some copy
7 editing that will be working with us when Jim gets
8 finished or as we are getting along. We need to get the
9 document out to you by February 4th and 5th, at least two
10 weeks before the meeting, at least.

11 DR. GORDON: And by then the recommendations
12 will be final and the document will then be for
13 discussion.

14 MR. GROFT: Right.

15 DR. GORDON: Okay? So there will then be a
16 couple weeks to read the whole document at that point.

17 MR. GROFT: And the work groups will have read
18 their own, individual sections as we go along between two
19 weeks hence and then before January 8th or so. But the
20 work groups will continue their involvement the whole way
21 through to the end. I think that was the desire of the
22 Commission, that they maintain that responsibility for

1 their section of the document through.

2 SISTER KERR: Steve, excuse me. I heard a date
3 of January 8th.

4 MR. GROFT: Yes.

5 SISTER KERR: And I wasn't sure what that was a
6 termination for and if it was, would we be getting
7 whatever we are supposed to comment on at least a few
8 days before Christmas? I mean if you are asking for some
9 other final input by the 8th, what is it we --

10 MR. GROFT: I think we want to get all the
11 recommendations resolved by the 8th of January. We want
12 to get all of the key words or phrases that people want
13 to have changed, that they have concerns with cleaned out
14 and cleaned up so that as we finish up the writing we
15 don't have to worry about those issues there.

16 DR. GORDON: And also, Steve, we want to get
17 everybody's concerns about the text by January 8th. Did
18 you follow the reasoning on that? So that if there are
19 concerns about a specific section that that can be worked
20 on. Meanwhile, the work group will be working on those
21 sections of the text, and then if there are things that
22 need to be changed or added to, then Jim or staff will be