

1 is in HHS, has any kind of -- I am going to propose a  
2 suggestion, that maybe having interdepartmental personnel  
3 on loan. So in other words, if the FTC was doing  
4 something, there was a way of borrowing people. So, when  
5 we talk about the staffing we also talk about sufficient  
6 interdepartmental or whatever, different cabinet  
7 departments so they could be shared, which would give you  
8 a real person on the ground in the other department to  
9 help coordinate things. So, it could be outside of HHS  
10 but they would be answering to this director or whatever  
11 this person is going to be called.

12 DR. WARREN: It depends on where the office is  
13 located as to whether or not you can borrow staff from  
14 other agencies. If this is an office that oversees all  
15 the various departments of government that are related to  
16 CAM, then I think you could borrow.

17 DR. FINS: It leads to the issue of the  
18 president implicitly, and that is what I was getting at.  
19 So I think we could perhaps say that it would have the  
20 opportunity to have interdepartmental borrowing as it  
21 were without actually saying that it should be at that  
22 level. But it would say that if that is the

1     functionality that is where it had to go.

2             DR. WARREN:   Good idea.

3             Charlotte?

4             SISTER KERR:   This is like looking for nitty-  
5     bitty -- it is not really nitty-bitty if it really became  
6     a problem, but say, for example, the recommendation that  
7     I was focused on yesterday about the demo project at the  
8     VA?  Now, say the VA read that recommendation, this  
9     report comes out and it is accepted, and they pick it  
10    right up and say, right, we are doing it.  Now, and then  
11    we have a centralized office whose job is to facilitate  
12    that recommendation.  Is there a potential conflict there  
13    of, like, they have got to then go back to this CAM  
14    Central and talk to them or can they just go ahead with  
15    the recommendation?

16            DR. WARREN:   I think when you start  
17    implementing the recommendation then all CAM Central does  
18    is just keep an eye on things.  I don't think they have  
19    to go back and particularly party with you, do they?

20            DR. GORDON:   Charlotte, maybe part of what you  
21    are talking about needs to be addressed a little bit more  
22    in the text as we describe the texture of the office and

1 of how it might interact.

2 DR. WARREN: That is my intention. The text of  
3 our committee is really probably going to be close to the  
4 last thing being written because of all the various  
5 committees that are having to put their stuff together.  
6 Then we have to take that as a compilation, come up with  
7 a written text, you all will get a copy of that, and that  
8 way for CAM Central it will be more of an overview of our  
9 recommendations.

10 Joe?

11 MR. PIZZORNO: Two things. First off, it  
12 appears that the advisory board has been left off of  
13 this. I still think we need to have the advisory board  
14 and specify that it include CAM, conventional, public  
15 health, and public representation.

16 DR. KACZMARCZYK: Joe, I beg to differ with you  
17 because in No. 3 where it says, "planning and convening  
18 conferences, workshops, and necessary advisory groups."  
19 It is on page 2, Line No. 30." When Donald was racing  
20 through he did not mention "necessary advisory groups."

21 MR. PIZZORNO: I saw that, but this is an  
22 advisory board for this office specifically.

1 DR. KACZMARCZYK: And it is the broad  
2 categories.

3 DR. WARREN: On No. 3.

4 DR. GORDON: I think the issue that Joe P. is  
5 referring to is that originally when we formulated this  
6 CAM Central Office, the overall advisory board was a very  
7 central aspect of that formulation.

8 DR. KACZMARCZYK: That is in the text and that  
9 text is in limbo as Don described because if you look at  
10 the process that we have discussed, it is going to be one  
11 of the last documents written. It is going to be  
12 probably be right there when the executive summary is  
13 being written.

14 DR. GORDON: Joe just wants to make sure it  
15 hasn't disappeared.

16 MR. PIZZORNO: I just wanted to make sure it  
17 hasn't disappeared, that is all.

18 DR. KACZMARCZYK: It will be there in some form  
19 in the text when it is written at a much later stage.

20 DR. WARREN: And I think what you are  
21 describing is the public advisory group we were talking  
22 about being in actual control.

1 MR. PIZZORNO: I am not sure about control or  
2 what, but it is an important part of it.

3 DR. WARREN: But it has a large overview of the  
4 situation.

5 DR. GORDON: So, I think what Joe is looking  
6 for confirmation of is that essentially as that was  
7 formulated by this group that is continuing, Don?

8 DR. WARREN: It is going to be continued.

9 MR. PIZZORNO: Now, the second thing is, and I  
10 think this is just restating what you just said, when we  
11 look at the proposed activities all these have to be  
12 changed since we just changed all of it in the process.

13 DR. WARREN: Effie?

14 DR. CHOW: No. 3, page 2, "planning and  
15 convening conferences, workshops," we should be  
16 facilitating planning as well, not we just do the  
17 planning and encourage others to encourage and facilitate  
18 other associations.

19 And the other thing is that we are going to  
20 implement our recommendations here. What about  
21 futuristic kind of thing? And if this is an ongoing  
22 central coordinating office, then I would think there

1 would be some updating or projection of future  
2 activities. Do you understand what I am talking about?

3 DR. WARREN: I am trying to follow that. Are  
4 you talking about --

5 DR. CHOW: This advisory group is --

6 DR. WARREN: The futuristic part of it, are you  
7 looking at what the advisory groups would do?

8 DR. CHOW: Well, rather than just implementing  
9 our recommendations, five years from now where is it  
10 going to be? Is it going to be reviewing the present  
11 status of situations and making further recommendations?

12 DR. WARREN: Effie, I believe we are going to  
13 be covering that in the text of the document where we  
14 explain what happens in successive years. We hope that  
15 this is a permanent program. We will try.

16 DR. GORDON: I think, though, that Effie is  
17 asking that -- and I think this is the same question as  
18 that came up with Joe -- that as that text gets worked  
19 out it needs to come back to the group as a whole.

20 DR. WARREN: Absolutely.

21 DR. GORDON: I think that what Effie is talking  
22 about is the proactive functions of that office, as well,

1 and that it is not just reviewing what is going on but  
2 that it takes certain stands. So, that is the  
3 information that we will be looking for.

4 DR. WARREN: Right.

5 MR. CHAPPELL: And I think some of the ongoing  
6 visioning will come out in the visioning section because  
7 I see there is an opportunity there to talk about some  
8 futuristic mechanisms.

9 DR. WARREN: Joe?

10 MR. PIZZORNO: Also, as we develop the language  
11 for this office further, the issue of budgetary authority  
12 I think needs to be addressed, too. I am concerned about  
13 their ability to not only facilitate this, but maybe  
14 there would be some situation where they need to do some  
15 funding of some activities, also.

16 DR. GORDON: Joe, I'm sorry. Just to clarify,  
17 you are suggesting what, a specific amount of budget, or  
18 what are you suggesting?

19 MR. PIZZORNO: I don't understand how these  
20 things work. But I do know that if you don't have a  
21 budgetary authority it really limits what you can do. So  
22 let's make sure we in our thinking process ensure that

1 that is covered.

2 MR. GROFT: Yes, Joe. They all will be  
3 incorporated into this, and your activities are dictated  
4 by your responsibilities that you identify when you write  
5 up the responsibilities of the office. It just carries  
6 forward.

7 I think you have your outside advisory group,  
8 you have your trans-agency advisory group, the activities  
9 flow. I think what has been given here is certainly  
10 enough to last another four to five years, at least.

11 DR. WARREN: What about the budget, how does  
12 that work?

13 MR. GROFT: The budget, that is another  
14 process. It is totally independent. That comes through,  
15 that an office works up and you get an idea. Here is how  
16 much we think we need, here are the responsibilities of  
17 the office, what it normally costs. For example, most  
18 new offices, they talk about five people staffing an  
19 office, a million dollars a year, or two million dollars  
20 a year for responsibilities, and then you have to justify  
21 how you spent your money and what you are going to spend  
22 it on. Then it is up to you and your supporters to

1 gather additional support for an increase of budget to  
2 justify other activities.

3 So it is a growth area. It is what has  
4 happened with Office of Alternative Medicine, and perhaps  
5 is what is happening currently with the Office of Cancer  
6 Complementary and Alternative Medicine. It depends on  
7 the activities and the desire to see an office grow.

8 DR. KACZMARCZYK: Charlotte?

9 SISTER KERR: I think I needed to hear the  
10 rationale again as to why we have not made a statement of  
11 opinion of where it should be under DHHS. Why didn't we  
12 say and what is the probability of it -- not that we are  
13 suggesting that would happen -- but that it would end up  
14 in some obscure place and not perhaps have the teeth we  
15 need?

16 DR. WARREN: What we are really looking at is  
17 getting the office established by the President first --  
18 that would be our first line -- Secretary of Health and  
19 Human Services, or then, Congress. Any of those offices  
20 can establish this. Preferably, the fastest way you are  
21 going to be able to do it is with the Office of the  
22 President, and that would be wonderful.

1           There are a variety of mechanisms for doing  
2 this through the Office of the President. One is, he  
3 just creates an office, just like he created this  
4 Commission.

5           Another is, he could do what is called OPIC,  
6 where you have half-governmental, half-public  
7 representation on a governing board. That is another way  
8 of doing it. Then it goes down to Department of DHHS.

9           There are a lot of ways of getting it done, but  
10 that seemed to be the best way, is to put it in and say,  
11 we are going to get this handled at the highest possible  
12 level we can.

13           Joe?

14           DR. FINS: I have two points, and I want to  
15 resurrect Joe Pizzorno's comment about the advisory body.  
16 As I read this, it looks like advisory groups, it is like  
17 having a conference or workshop. It is not as central to  
18 the constitution of the office, and so I really think we  
19 are establishing an office with the appropriate staff  
20 with an advisory body to do the various things. I think  
21 it was part of the conception and I think it will help  
22 balance it.

1           The other thing is that I really would like a  
2           little clarification on your thinking about the  
3           relationship of this office to NCCAM. And one is a  
4           research entity, but I think it is important that we  
5           spend a little time thinking about that relationship: Is  
6           it hierarchal; is it on parallel tracks; et cetera.

7           Have you guys thought about that?

8           DR. WARREN: NCCAM is basically associated with  
9           research. That is their basic premise. There is a huge  
10          pie out there called CAM, and research makes up a nice  
11          percentage of it, but it is by no means all of it. I  
12          think that this office will take up a lot of the slack  
13          that NCCAM can't fulfill at this point.

14          The NCCAM has a clearinghouse. They will still  
15          have their clearinghouse. People will call into CAM  
16          Central, and we may be referred to the clearinghouse.

17          DR. FINS: I would just want to maintain the  
18          independent scientific peer review dimension about  
19          funding. I mean, this office might determine, to some  
20          extent, what kind of funding in the aggregate goes to  
21          NCCAM, but I wouldn't want this office to make decisions  
22          about what kind of research gets funded, other than

1 establishing the appropriation, perhaps, to NCCAM. I  
2 think it has to be based on merit and scientific, the  
3 normal NIH review process.

4 DR. WARREN: I understand that.

5 Wayne?

6 DR. JONAS: It doesn't look like there is any  
7 danger of that since the entire Research section was left  
8 out of it.

9 [Laughter.]

10 DR. JONAS: So, I am wondering, was that an  
11 oversight?

12 DR. KACZMARCZYK: It was quite intentional,  
13 Wayne.

14 DR. JONAS: By design? Well, maybe we should  
15 discuss that element.

16 DR. KACZMARCZYK: By design.

17 DR. JONAS: And can you explain that?

18 DR. KACZMARCZYK: It was omitted by design  
19 because this would focus on non-research aspects of CAM.

20 DR. JONAS: Okay. I think that we have got a  
21 problem there because the Commission has explicitly  
22 addressed research and has a number of recommendations

1 about research and we have discussed the relationship  
2 between the Commission's recommendations, the various  
3 other agencies that are non-NIH-based that need  
4 facilitation and need to have research done, and the  
5 collaboration and cooperation with NCCAM and OCAM and the  
6 other institutes about that that still require some kind  
7 of HHS coordination and oversight.

8 DR. FINS: This is where the director of NCCAM  
9 would be logically one of the folks who would sit on the  
10 advisory body. But I think that if we don't spell out  
11 our conception of the relationship, it could be perceived  
12 as threatening. I mean there should be a tremendously  
13 good alliance between those two entities. But I think we  
14 need to prevent confusion by being more explicit about  
15 that relationship.

16 DR. JONAS: I also think that we can put in  
17 recommendations but we need to word them properly so that  
18 it is clear that the goal of CAM Central is to work  
19 collaboratively with other entities to facilitate and  
20 coordinate the research process. I think it is very easy  
21 to do that. I think leaving them out, like you said,  
22 makes it even more complicated.

1 DR. GORDON: But what I am hearing you say,  
2 there are two pieces here. One is that the research  
3 piece needs to be back in, number one. Number two, more  
4 generally, this has been coming up. What we need is --  
5 and I think it is time to do it now -- is to do the  
6 description of the function and the structure of this  
7 office. We made virtually all the recommendations that  
8 we are going to make. And I think what I am hearing from  
9 a number of people from a number of different  
10 perspectives is we want all of that fleshed out. We want  
11 the advisory committee back, we want the sense of how the  
12 office is going to relate, and that the next step would  
13 be for us to look at that and then have a dialogue with  
14 you about that.

15 DR. WARREN: I believe the "fleshing out" as we  
16 call it will occur now as soon as this 10-day period is  
17 up where get the recommendations out. And once we get  
18 them back, then we can flesh this thing out completely.

19 DR. FINS: We know the categories of  
20 recommendations. We know what the kind of  
21 functionalities will be that will be required to do that.  
22 I think it is probably reasonable to get a sense of what

1 the structure of that office is going to be in the same  
2 time frame as the 10 days.

3 DR. KACZMARCZYK: That structure, Joe, so  
4 depends upon where it is located.

5 DR. FINS: For us to decide where it goes? Or  
6 is that presumptuous?

7 DR. KACZMARCZYK: I think it is rather  
8 presumptuous.

9 DR. GORDON: I think that there are certain  
10 elements that we made clear and we may or may not make a  
11 recommendation about where it should be located. But it  
12 has been pretty clear from the discussion that there are  
13 certain functions and certain kinds of relationships and  
14 certain kinds of structures, for example, the advisory  
15 committee that we want the office to have.

16 DR. KACZMARCZYK: That is in the briefing book  
17 for the October 4th through 6th.

18 DR. GORDON: I understand. I am saying what  
19 people are looking for is to see that again and to see  
20 how it all connects up.

21 DR. KACZMARCZYK: And because it was presented  
22 previously, we did not reprise it for this meeting.

1 DR. GORDON: Understood.

2 DR. KACZMARCZYK: Steve has a point.

3 MR. GROFT: Yes. It is time to construct this  
4 section as a section, no longer just as a group of  
5 recommendations but it is to give everyone an idea of the  
6 responsibilities, functions, activities. I think that is  
7 something we can start and have done.

8 DR. GORDON: What do you see as, then, the time  
9 frame?

10 MR. GROFT: I think the same time frame, yes.

11 DR. GORDON: Okay. The same time frame meaning  
12 10 days?

13 MR. GROFT: Yes.

14 DR. GORDON: Okay.

15 MR. GROFT: I don't view it as a long section.

16 DR. GORDON: I think the issue that is still  
17 out there which several people mentioned is do we want to  
18 leave it at the highest level or do we want to make a  
19 specific recommendation? It sounds like some people are  
20 maybe wanting to revisit that question, Don. I don't  
21 know.

22 DR. WARREN: Well, I thought about that and

1 wondered if you wanted to put all your eggs in one basket  
2 and shoot for one level. You could do that, but by  
3 leaving the proposal the way it is with the president,  
4 Secretary of DHHS, and Congress, and you pretty well  
5 leave the door open for any of those three to pick up the  
6 ball and run with it.

7 SISTER KERR: Doesn't the office of the  
8 president -- wouldn't it potentially go after the  
9 administration changes?

10 DR. WARREN: That is always a possibility.

11 SISTER KERR: And Congress is only going to  
12 appropriate monies and make offices.

13 MR. GROFT: I think after a determination has  
14 been made how you create the office, whether it is  
15 created administratively or legislatively, and that is  
16 why of everything you like a legislative mandate because  
17 then to undo it you need another legislative mandate to  
18 undo it. It is not our decision. And I think we are  
19 just saying one of the three groups can create this and  
20 whoever will do it and whoever would make that decision.

21 DR. WARREN: We covered all this in October and  
22 we came up with a consensus, and I think we did it and I

1 am so proud of this group for doing it.

2 Yes, Tom?

3 MR. CHAPPELL: But information. Is there an  
4 equivalent to this with conventional medicine in the  
5 government?

6 DR. WARREN: I don't know that answer.

7 MR. GROFT: I would say the Office of Research  
8 on Minority Health or the Office of Women's Health and  
9 the Office of Minority Health, both down at the  
10 department level. And there are probably one or two  
11 others at the White House. AIDS Policy. So you have a  
12 thread then working the whole way down through the other  
13 departments and agencies throughout, even like the Office  
14 of Surgeon General, another possible location.

15 Yes?

16 DR. WARREN: Effie?

17 DR. CHOW: We were appointed or our commission  
18 was set up by executive order by the president and it was  
19 one of the few commissions that are actually appointed by  
20 the president, I understand. It would behoove us to keep  
21 it at the highest level and not delegate it down to low  
22 levels.

1 MR. GROFT: But see, that is not our decision,  
2 though.

3 DR. CHOW: No, I know.

4 MR. GROFT: All we can do is state where we  
5 think it could go and someone else has to make the  
6 decision.

7 DR. CHOW: But Steve, I am not disagreeing. I  
8 am saying I agree with this comment here. I just want to  
9 point out that we were appointed at the highest level and  
10 we should strive to maintain at the highest level.

11 DR. WARREN: Effie, if you go back to October,  
12 that information is in our handouts then about where the  
13 possibilities of the thing being placed, and that  
14 clarifies it.

15 DR. FINS: I think the way to make that  
16 argument is to talk about all the various  
17 functionalities, personnel needs, and interrelationships  
18 and then to meet those objectives. It will be pretty  
19 clear at what level, whether through a congressional or  
20 an executive directive or whatever, we will have to go.

21 DR. WARREN: I believe that we are going to be  
22 able to flesh this thing out completely. If you get your

1 questions to you and back to the committee before the  
2 eight-day mark, then we can have two days to put it  
3 together before the 10-day mark.

4 DR. GORDON: Don, I didn't understand the last  
5 thing you said. What are you looking for? I think a lot  
6 of the questions have come today. What else are you  
7 looking for?

8 DR. WARREN: Well, there are going to be some  
9 modifications, and once the modifications are in then we  
10 will finish fleshing out. We are going to do a lot of  
11 work on it between now and then and we will get it to  
12 you. But the final details will only occur after all the  
13 changes have occurred or been brought in.

14 DR. GORDON: Okay. Anything else, or are we  
15 coming to a close? Let me summarize and then we are  
16 going to come to a closing.

17 **Session Summary**

18 What I am hearing, strongly, is, yes, we  
19 continue to have a consensus for CAM Central; yes, the  
20 five general areas that have been described, the areas  
21 and what the commissioners are looking for, is a more  
22 detailed description, a good deal of which was there in

1 the October briefing book, but a detailed description of  
2 the advisory council, of the functions of this office, of  
3 the relationships to other offices within the government;  
4 and that we have a recommendation that it be at the  
5 highest level; that if we want to make it more specific,  
6 which it sounds like we don't -- we have not decided to  
7 make it more specific -- if we did, it would come out of  
8 that entire description of the office.

9           So we could conceivably revisit the question if  
10 it became -- Joe, are you with me on this? I want to  
11 make sure you are here -- if it became obvious that all  
12 the functions that you just described dictated a  
13 particular level, we might suggest that as a preferred  
14 level.

15           So that is where we are, but at this point,  
16 what we are suggesting is simply that it be at the  
17 highest level.

18           Wayne, go ahead.

19           DR. JONAS: And that the research  
20 recommendations be also --

21           DR. GORDON: Thank you. Thank you. And that  
22 the research recommendations be folded back in, and that

1 all the specific recommendations be made in accord with  
2 the wording that has come out of this meeting. Okay?

3 DR. WARREN: Thank you.

4 DR. GORDON: Okay. Thank you all very much.

5 Let's take a five-minute break. I want to say  
6 to our guests here, some of you who weren't here early  
7 this morning, that Don Warren will be chairing the last  
8 part of the session, that because of security  
9 considerations and plane rescheduling, I have to leave  
10 and go to the West Coast, but I will make a commitment to  
11 reading all of the material that has been submitted.

12 So take a five-minute break. We will come back  
13 at 4:00 with the first panel of public presentations.

14 I want to thank everybody. Really, we have  
15 done a great job. It has been terrific.

16 [Applause.]

17 DR. GORDON: And I want to thank everybody for  
18 really moving to the highest level in dealing with these  
19 recommendations.

20 [Recess.]

21 **Public Comment Session**

22 MS. CHANG: Would the following five people

1 please come up to the speakers' table: Boyd Landry;  
2 Candace Campbell; Fabrizio Mancini; Jerry Hardee; Matthew  
3 Irwin.

4 Just as a reminder, you will each have three  
5 minutes to make your oral statement, and then after you  
6 all five are done speaking, we will go to a quick Q&A.  
7 Thank you.

8 DR. WARREN: I would like to apologize to our  
9 panelists. A lot of our commissioners had flights they  
10 had to catch. Because of security reasons they are gone  
11 a little early, but we have to be out of here by 5:00.  
12 They close the room.

13 Mr. Landry. Boyd Landry is here, and he is  
14 with the Coalition for Natural Health.

15 Would you like to start off, please?

16 MR. LANDRY: Well, I have got a plane to catch,  
17 too, but I am still here.

18 Anyway, thanks for allowing me to speak again.  
19 This has been the sixth or seventh time that I have been  
20 fortunate enough to be allowed to speak.

21 I want to start with a overreaching theme, I  
22 guess to borrow a term that has sort of surfaced here in

1 this meeting. Instead of creating mechanisms and systems  
2 which would allow CAM to grow, you have recommended  
3 mechanisms and systems that place CAM in the same failing  
4 health care system that we have today. A lot of the  
5 recommendations that have come forth over these last two  
6 days place CAM into this failing health care system that  
7 we have today.

8 In addition, it doesn't -- this microphone is  
9 not very good. In addition, the recommendations do not  
10 clearly balance the needs of practitioners who want to be  
11 protected but not regulated with the false notion that  
12 access is predicated by regulation. If regulation was  
13 the key to access this phenomenon would have never  
14 occurred.

15 With respect to Education, usage of terms and  
16 phrases like "accredited" and "appropriately trained"  
17 designate Big Brother as the determinant of how these  
18 terms are met.

19 With respect to Access and Delivery, these  
20 recommendations are more concerned with delivery rather  
21 than access. In addition, there is a lack of respect for  
22 the Minnesota Law that is working effectively to date.

1 Furthermore, the most important recommendation in this  
2 section should be the epidemiological surveys to  
3 determine use and patterns of uses as well as which  
4 certain practices should be regulated.

5 On to Coverage and Reimbursement. One of the  
6 principal tenets of holistic care is for the patient to  
7 have complete and full responsibility for their own  
8 health care decisions. As long as there are insurance  
9 companies paying and controlling services patients do not  
10 have complete and full responsibility. When people dig  
11 out of their own pockets cash, the responsibility is  
12 greater. Finally, when you get out into the real world  
13 at the state level, consumers are not beating down doors  
14 to get certain types of practitioners regulated or  
15 licensed. Additionally, there isn't a significant number  
16 of cases of verifiable harm to warrant state  
17 intervention, which is what states look at first before  
18 they ever talk about regulation of professions and  
19 businesses and occupations, excuse me.

20 And finally, I want to leave you with one final  
21 thought, and this was a quote in 1977 in the "UCLA Law  
22 Review." You might see how it pertains today.

1           "By creating a professional monopoly, licensing  
2     contributes to both the doctor shortage and the resulting  
3     inflated prices. A leading economist argues" -- this is  
4     very short -- "that medical licensing has in addition  
5     diminished the quality of medical practice by reducing  
6     the number of physicians, the number of hours physicians  
7     can devote to their important tasks, the incentive for  
8     research and development, and the ability of individuals  
9     to collect from physicians for malpractice. Analysis by  
10    this expert and others suggests that any savings  
11    resulting from the inhibition of quackery by licensing  
12    are often offset by costs created by the licensing  
13    itself." Thank you.

14           DR. WARREN: Thank you very much.

15           Candace Campbell, Association for Health  
16    Freedom.

17           MS. CAMPBELL: I am here today on behalf of the  
18    Integrated Health care Consortium, which is a multi-  
19    stakeholder group that was formed for one purpose, and  
20    that was to organize the national policy dialogue to  
21    advance integrated health care.

22           This was a summit-style working meeting held in

1 the fall of this year, and the goal of the meeting was to  
2 identify common ground among diverse groups of health  
3 care stakeholders who are already involved at some level  
4 in providing, creating, or funding integrated health  
5 care.

6 Nearly 60 individuals participated by  
7 invitation, each one representing a segment of integrated  
8 health care and each one a leader in their respective  
9 fields. Together we represented providers, educators,  
10 researchers, payers, and consumers who have a commitment  
11 to safely and effectively advance integrated health care.  
12 We believe it was a landmark event representing the first  
13 time that such a diverse section of the industry met to  
14 discuss public policy and identify common ground.

15 I am happy to report that the meeting was a  
16 tremendous success. Not only did it offer people an  
17 invaluable opportunity to meet players they wouldn't  
18 ordinarily meet, it gave us all a chance to discover that  
19 the others didn't have horns. Despite some negative past  
20 experiences, distrust, concern about coaptation, and a  
21 host of other potential roadblocks to productive  
22 dialogue, we were delighted to find a high degree of

1 common ground, and I think we managed to get way past the  
2 baggage that has prevented us from working together in  
3 the past. In fact, numerous new relationships were  
4 established and ad hoc groups were formed to undertake  
5 several of the key tasks identified in the process.

6 I would like to call your attention to just  
7 several of those goals that kept coming up in our  
8 discussions because they represent areas of consensus  
9 that you may want to factor into your decision-making.  
10 We have prepared a preliminary report detailing these  
11 goals and others, and we expect to have a final report  
12 ready in January, which we would be happy to share with  
13 all of you.

14 One idea that really caught fire was the  
15 creation of a federal office that would be responsible  
16 for coordinating the switch to an integrated health care  
17 system. It would also help realign the focus of health  
18 care from disease treatment to health promotion and  
19 disease prevention. Support for this idea cut across all  
20 practitioner types and ideologies and we believe  
21 represents a strong desire to move public policy towards  
22 prevention.

1           This idea has been floated in several  
2 iterations over the past few years. We want to stress  
3 that the version of a federal office we support focuses  
4 on the creation of an integrated system, not on promoting  
5 CAM. The term "CAM" is, we hope, a short-lived one that  
6 will eventually be outmoded by integration.

7           As an aside, I should mention that to us  
8 integration does not mean sublimation but rather working  
9 together so that each modality retains and contributes to  
10 health care its own genius.

11           A second recommendation generated through our  
12 work was the creation of an agency that would act a  
13 clearinghouse for defining the qualifications and scope  
14 of practice for all health care providers.

15           Is that my three minutes? Okay.

16           I will just tell you quickly the third  
17 recommendation was that Congress and federal agencies  
18 responsible for health care research should significantly  
19 increase their allocations for health promotion and  
20 disease prevention, examining the role of CAM and  
21 integrated approach in these areas. Thank you.

22           DR. WARREN: Thank you, Ms. Campbell.

1 Dr. Fabrizio Mancini, President of Parker  
2 Chiropractic College.

3 DR. MANCINI: Thank you so much for this  
4 opportunity, and I want to commend you on all your  
5 efforts of this Commission.

6 I am here primarily to talk about two points,  
7 and the first one is the idea of the chiropractors being  
8 primary care providers. I would like to start by  
9 referring to the ACC paradigm, the Association of  
10 Chiropractic Colleges, which is a document that you have  
11 already been exposed to but a document that also has been  
12 embraced by all the leadership in chiropractic, which  
13 states that the purpose of chiropractic is to optimize  
14 health. The principle is that the body's innate  
15 recuperative powers are affected by and integrated  
16 through the nervous system and then the practice which is  
17 to establish a diagnosis, facilitate neurological and  
18 biomechanical integrity through appropriate chiropractic  
19 case management, and to promote health.

20 I entered the chiropractic field primarily  
21 because of this premise, of a premise that believes that  
22 the body is a self-regulating and self-healing mechanism.

1 I believe most of us in this room will agree with that,  
2 and it is the one thing that I believe was causing all of  
3 us to look for a better health care system for our people  
4 in the United States.

5 I have also included in the packet a catalogue  
6 and a video because I believe that we need to recognize  
7 how high of a caliber the chiropractic occupation has  
8 evolved over the last 106 years. And through the  
9 catalogue you will be able to recognize specifically our  
10 course curriculum and how diverse our curriculum is in  
11 order to support the position of primary care provider  
12 for chiropractors. Right now, the CCE, one of our  
13 accrediting bodies, has raised the minimum requirements  
14 for entering chiropractic to 90 hours, which means that  
15 we are attracting a much higher level of academic  
16 prospective student.

17 Also, I would like to mention just a point on  
18 Title No. 7 under Student Loan Forgiveness for MUAs and  
19 to support that effort. And just to give you an example,  
20 in our school we have over 700 students. And I sent an  
21 e-mail and just asked the students randomly, and I said,  
22 "How many of you will be interested in supporting an

1 underserved area if the government is able to help you  
2 and forgive some of your loans?" And within 24 hours we  
3 received over 50 e-mails saying that they would like to,  
4 and I have submitted that to the Commission. That also  
5 states all the areas that they have been willing to  
6 serve.

7 My point in this is to be able to just mention  
8 to you that right now other portal-of-entry professions  
9 such as medicine and osteopathy are part of that system,  
10 and I believe chiropractors should be part of that, too.

11 And in closing, I have also enclosed just a  
12 brief summary of some of the research to support the  
13 position of primary care provider and also the joint  
14 research that we are doing also with the medical  
15 community in order to continue to advance chiropractic  
16 research and the efficacy that we have through  
17 chiropractic care. Thank you so much for your time.

18 DR. WARREN: Thank you.

19 Dr. Jerry Hardee, Sherman College of Straight  
20 Chiropractic.

21 DR. HARDEE: Commissioners, thank you so much  
22 for allowing this dialogue regarding loan forgiveness for

1 chiropractic students. Much of what I have to say will  
2 echo most of a remark by Dr. Mancini.

3           The chiropractic profession is based on the  
4 premise that it exists to nurture and advance a simple  
5 and powerful idea. We recognize that the body possesses  
6 the inborn capacity and striving to maintain itself in a  
7 state of optimum health. All of our activities  
8 concentrate on exploring, evaluating, and advancing the  
9 concept that the body is a self-regulating system that  
10 continuously adapts to its ever-changing internal and  
11 external environments to ensure its survival and health.

12           The nervous system is the communication network  
13 that directs this self-healing and self-maintaining  
14 capacity and is the focus of the straight chiropractic  
15 profession.

16           Sherman College educates its students and the  
17 community that the human body is an intelligent,  
18 functioning system that interacts dynamically with its  
19 environment by constantly adapting to internal and  
20 external changes. We understand that the body is best  
21 able to carry out that adaptation when there is no  
22 interference to the channels of communication that share

1 information between the brain and all the organs and  
2 systems of the body. The dedicated men and women who  
3 choose to serve humanity as doctors of chiropractic have  
4 been educated at world-class levels to take this message  
5 to communities where they will establish their practices  
6 and improve the quality of the lives of the people they  
7 serve.

8 Today we ask that you honor their commitment  
9 and celebrate their outstanding achievements and  
10 anticipated contributions to our society by offering them  
11 the opportunity to enter the profession knowing that they  
12 will have a chance to serve their communities in lieu of  
13 full loan repayment. In other words, loan forgiveness.  
14 With the 16 chiropractic colleges across the country  
15 graduating several thousand doctors of chiropractic each  
16 year whose educational debt load is substantial, we would  
17 very much appreciate your intentional effort to allow  
18 them to begin the professional phase of their lives less  
19 burdened by loan repayment in return for their  
20 professional services.

21 I submit to you today a petition from Sherman  
22 College with over 100 names of students who have agreed

1 that if given the opportunity in some form of loan  
2 forgiveness they would be willing to serve in MUA areas.

3 I ask that you today consider the heavy load  
4 that they have when they graduate, knowing full well that  
5 for up to 10 years many of them will be repaying loans.  
6 Thank you for joining with our academic community in  
7 recognizing a need for these students to have this  
8 opportunity.

9 And I have saved a few minutes just to say that  
10 with what I have gone through to get here today since 4  
11 a.m. this morning, I plead with you to take this  
12 opportunity to discern seriously the burden that these  
13 students face when they graduate. They deserve the  
14 opportunity to have some form of loan forgiveness. Thank  
15 you.

16 DR. WARREN: Thank you very much, Dr. Hardee.

17 Dr. Matthew Irwin, Group for Scientific  
18 Reappraisal of HIV/AIDS.

19 DR. IRWIN: Thanks. Before I start in on my  
20 topic, just listening to these people it has made me  
21 think about things and what you guys are trying to do,  
22 which is to integrate holistic, alternative medicine into

1 the framework that we have. And it reminds me that the  
2 framework that we have relies on having a lot of sick  
3 people. It is sort of antithetical to the idea of health  
4 promotion.

5 I have an uncle who was a CEO of a large  
6 hospital in Los Angeles for about 30 years and he,  
7 knowing my interest in holistic medicine, one time said  
8 to me, the main agenda on my table every day was empty  
9 hospital beds that had to be filled.

10 I don't know how that integration would work,  
11 but it is food for thought that somehow people are  
12 successful with health promotion and how do they do that  
13 within this system which really rewards you for having as  
14 many sick people around as possible. At least rewards  
15 you financially.

16 My topic that I came to talk about is HIV and  
17 AIDS. I have actually come to see that as the defining  
18 issue that pits the host versus the germ theory, going  
19 back, Pasteur and the debates that he had with people.  
20 Because AIDS came along as that you might have a healthy  
21 host but it really doesn't matter because HIV is so  
22 powerful and so strong and so devastating. And I have

1 actually come to see that personally I don't believe that  
2 that is true.

3 I have known people who have been HIV-positive  
4 and healthy for 16, 17, 18 years, and I encouraged one of  
5 them to get retested because I don't trust the test very  
6 much. He tested negative. Another friend of mine has  
7 tested positive and then negative and now positive again.  
8 She tends to test positive when she is pregnant.

9 And I think what it comes to is I am not really  
10 asking to do anything except to consider that you might  
11 actually look into some of these things. I have a friend  
12 who is HIV-positive who asked me to come here today  
13 because he has read some of my articles. That is really  
14 the only reason I am here. It happens that he is the son  
15 of a nationally known chiropractor who is, I think, the  
16 head of a large national chiropractic organization.

17 But I also brought a little article which  
18 represents what I think could happen and would be a  
19 fertile area for research. It is from the "Times of  
20 India" about a small town in India, or maybe it is a  
21 city. I don't really know. I haven't researched this to  
22 see how accurate it is. Basically, it is a group of

1 counsellors which counsel HIV-positive people in India in  
2 Mumbai, which is, quote, the AIDS capital of India.

3           There are two groups that they interviewed for  
4 this article, Salvation Army and Counselling and Allied  
5 Services. They basically say that according to their 10  
6 years of experience there is strong evidence to show that  
7 the damage caused to the immune system can be reversed.  
8 This happens when people change their habits of substance  
9 abuse, eat nutritious food, involve themselves in  
10 community service, practice discipline and hygiene,  
11 receive counseling, family, and social support. Such  
12 persons emerge stronger and healthy.

13           They go on to say that in the 10 years of their  
14 program, they have taken care of and attended to over 900  
15 patients, only 15 of whom have died, and they died of  
16 malnutrition and tuberculosis.

17           So what I say to you is, when you hear things  
18 about people who are saying crazy things about HIV --  
19 Peter Duesberg is the famous dissident -- I actually  
20 think it is worth reading what he has written, but he is  
21 only one of several hundred M.D.s and/or Ph.D.s who have  
22 signed statements calling for reappraisal of this issue.

1 I see it as a central battleground between the host-  
2 versus-the-germ issue.

3 DR. WARREN: Thank you very much.

4 Do the commissioners have any questions for our  
5 panel? Joe?

6 MR. PIZZORNO: This is to the chiropractic  
7 doctors here. One of the key challenges we have been  
8 having is how to go about doing loan forgiveness programs  
9 that include CAM practitioners. And one of the key  
10 elements has been the ability to provide care in  
11 collaboration with the conventional medical doctor versus  
12 ability to provide care independently without a medical  
13 doctor being there.

14 If we are looking at an underserved area where  
15 there is no medical doctor available, at what level are  
16 your graduates able to provide services?

17 DR. HARDEE: I think there are two or three  
18 ways. The first, and I think the most important, is to  
19 help people prepare themselves to maintain good health.  
20 In other words, to me one of the greatest ways to help  
21 people health-wise is to help them eat better, show them  
22 how to prepare themselves better such that they can

1 prevent many of the things that simply would not happen  
2 if they take better care of themselves.

3 We are doing a lot of it now. Our students are  
4 doing quite a bit of that now, going into communities and  
5 talking to people about how they ought to make sure that  
6 they are free of subluxations, make sure that they have  
7 good diets, make sure that they do the things that they  
8 ought to do in order to not have those physical problems  
9 that get to the point that they are not able to help them  
10 with.

11 DR. MANCINI: I think that you will find today  
12 in chiropractic that there are many practitioners right  
13 now, chiropractors working alongside with medical doctors  
14 in integrated practices. That has become a very popular  
15 way of practicing.

16 We have in our school -- in fact, this incoming  
17 class -- four medical doctors registered, and two Ph.D.s.  
18 And they all are amazed at the preparation of the  
19 chiropractic education, and that is what I find that you  
20 will find in our curriculum, the basis of chiropractic  
21 education that gives them a very strong support in  
22 providing the adequate care whenever there is not a

1 medical practitioner around.

2 At the same time, the chiropractors are very  
3 much aware of the limitations as far as their scope of  
4 practices, and as you look within the states, it varies.  
5 We have a few states that are very limited in their  
6 scope, and you have some states that are very broad in  
7 their scope. I think that as long as our students and  
8 our graduates understand the primary purpose of the  
9 chiropractor is the overall well-being of the patient and  
10 the preparation that we are giving them as a foundation,  
11 that they are very well prepared to handle that.

12 DR. WARREN: Tom?

13 MR. CHAPPELL: Thank you all for being here  
14 today. I wanted to ask Ms. Campbell --

15 DR. WARREN: Speak into your mic, Tom.

16 MR. CHAPPELL: I wanted to ask Ms. Campbell  
17 about the consortium and whether or not there is a sense  
18 that you may evolve into a trade association. Have you  
19 had any such discussions or visions?

20 MS. CAMPBELL: No. When we organized this, we  
21 said specifically our goal was not to become another  
22 organization. We have started an umbrella group that is

1 a national policy working group, and that is what we are  
2 looking at as a vehicle to implement the recommendations  
3 that come out of our meeting. So that, everybody  
4 maintains their own autonomy. We don't have to compete  
5 for funding, but it is a way to coordinate the  
6 activities.

7 DR. WARREN: Effie?

8 DR. CHOW: Yes. Also, thank you very much,  
9 all, and nice to see you.

10 Ms. Campbell, I have read your partial  
11 document, the reports, and I am interested in your future  
12 Fuller document on that. You know that one of our  
13 recommendations is to establish a CAM Central  
14 Coordinating Center. Do you see your group working  
15 closely at hand, should that office be instituted?

16 MS. CAMPBELL: Absolutely.

17 DR. CHOW: And how?

18 MS. CAMPBELL: I think of all the things that  
19 we discussed. That was probably the first and foremost,  
20 to get consensus. Everyone agreed that that was  
21 necessary, to have some kind of coordination at the  
22 federal level.

1           Our conversation did evolve, however, from a  
2 CAM office, which is where we started the conversation,  
3 into something that was more about promoting an  
4 integrated health care system because we were a little  
5 afraid of institutionalizing CAM, which means we maintain  
6 an allopathic existing system and just keep adding CAM.  
7 It is always other than, and we didn't want to promote  
8 that. I think if you call it a CAM Office, you  
9 institutionalize it, and forever, then, you are stuck  
10 with that model.

11           DR. CHOW: Thanks for that input.

12           DR. WARREN: Boyd Landry, I appreciate your  
13 observations and your being here through all this time.  
14 Sometimes your head-nodding kind of gets to me, but  
15 that's okay.

16           Ms. Campbell, I want to thank you for providing  
17 all the information from your meeting to us that supports  
18 us. We really appreciate that.

19           Dr. Mancini, I am going to see him again next  
20 week. My son graduates from Parker Chiropractic next  
21 week. I also know how the financial aspect of getting  
22 out of chiropractic school because I have got that burden

1 at this point. My third son is now accepted into your  
2 school, so it looks like I have double the burden.

3 Good luck with getting reimbursement for an  
4 underprivileged area, because when I got out of dental  
5 school, that is the way I paid off my loans, moving to an  
6 underprivileged area.

7 Dr. Hardee, thank you for your comments.

8 Dr. Irwin, I too have seen HIV-positive tests  
9 turn to HIV-negative tests through complementary  
10 alternatives. Thank you for your input.

11 Any questions, other than that?

12 [No response.]

13 DR. WARREN: Thank you all very much.

14 [Applause.]

15 MS. CHANG: Thank you. If the following five  
16 speakers would come up to the table: Dr. Ginette Hemley;  
17 Mr. Ian Cyrus; Dr. William Rutenberg; Dr. Remy Coeytaux  
18 -- I apologize if I mispronounced that name -- and  
19 finally, Mr. John Borneman.

20 Again, to remind you, you have three minutes to  
21 make an oral statement. After you all have finished  
22 speaking we will ask a few questions. Thank you.

1 DR. WARREN: I would like to start with Ginette  
2 Hemley, Ph.D., of World Wildlife Fund.

3 Yes, ma'am?

4 DR. HEMLEY: Thank you. It is a pleasure to  
5 have this opportunity to address the Commission, and to  
6 offer an environmental perspective on complementary and  
7 alternative medicine policy, perhaps a slightly different  
8 slant from the issues you have been dealing with today.

9 World Wildlife Fund is actively involved in  
10 conserving threatened and endangered wildlife and  
11 wildlife habitats around the world with programs in over  
12 100 countries. Our interest in CAM, and in particular,  
13 in traditional Chinese medicine, stems from the use of  
14 animal and plant derivatives in the manufacture of these  
15 medicines, some of which are from species that are  
16 increasingly scarce in the wild.

17 The perceived medicinal benefit of tiger bone,  
18 rhino horn, deer musk, bear gall bladder, and other  
19 derivatives of endangered and protected species,  
20 continues to drive a demand that generally exceeds  
21 supply, despite being prohibited or regulated in most  
22 countries.

1           We actively support efforts around the world to  
2 curtail poaching and illegal trade of wildlife through a  
3 number of ways. We have spearheaded efforts in both  
4 North America and East Asia, particularly in China, to  
5 build alliances with traditional Chinese medicine  
6 specialists and practitioners, with the aim of developing  
7 and promoting alternatives to endangered species products  
8 through close collaboration with institutions such as the  
9 American College of Traditional Chinese Medicine in San  
10 Francisco, and with China's State Administration for  
11 Traditional Chinese Medicine. We have undertaken a  
12 variety of educational efforts to raise awareness about  
13 these problems.

14           Conservation policy is turning, increasingly,  
15 to market-based incentives, and this approach is  
16 particularly promising, we believe, for the traditional  
17 medicine industry in China and other countries, including  
18 the United States.

19           It is our hope that manufacturers and traders  
20 will recognize the potential for greater market  
21 penetration and profit if they offer products that meet  
22 basic content standards, and certify that they are free

1 from adulterants and derivatives of endangered animals  
2 and plants.

3 We believe there are several areas of potential  
4 common interest between the Commission and the World  
5 Wildlife Fund, and in fact, the conservation community as  
6 a whole.

7 Your concern that biological and botanical  
8 derivatives of CAM be clearly labeled matches our concern  
9 that packages certify the absence of derivatives from  
10 endangered species.

11 Your focus on research to ensure the safety and  
12 efficacy of alternative medicine complements our interest  
13 in developing alternatives to medicines that rely on  
14 endangered animals or plants.

15 Finally, your interest in the quality of  
16 licensure of practitioners mirrors our concern that  
17 licensing requirements include training in the use of  
18 alternatives to medicinal derivatives of endangered  
19 species.

20 We would welcome your consideration of the  
21 following three recommendations for possible inclusion in  
22 the Commission report.

1 First, we recommend that standards be  
2 established and certification procedures developed to  
3 assure consumers that medicines do not contain heavy  
4 metals or other adulterants, or any endangered animals or  
5 plants. This recommendation could be integrated with the  
6 Commission's recommendation that biological and botanical  
7 derivatives be clearly labeled to enable consumers to  
8 determine the contents of medicinal products.

9 Second, we recommend that research include  
10 exploration of natural alternatives to traditional  
11 medicines that currently rely on derivatives from  
12 endangered species. And we support the Commission  
13 recommendation that research be expanded to assure the  
14 efficacy and safety of CAM and believe that our  
15 recommendation could be incorporated here.

16 Then finally, we recommend that licensing  
17 procedures for CAM practitioners include a requirement  
18 that licensees demonstrate an understanding of  
19 alternatives to medicinal products that are derived from  
20 species that are endangered or protected by certain  
21 international treaties or laws, and believe that this  
22 recommendation could be incorporated into that, related

1 to credentials.

2 Just to conclude, we believe that these  
3 recommendations could enhance the level of public  
4 acceptance of CAM and would also at the same time  
5 contribute to national and international conservation  
6 goals and interests. Thank you very much.

7 DR. WARREN: Thank you, Ms. Hemley.

8 Ian Anthony Cyrus, M.S., American Association  
9 of Oriental Medicine.

10 MR. CYRUS: Thank you, Commissioners, for  
11 allowing me to address the Commission.

12 My name is Ian Cyrus. I am a professional  
13 practitioner of acupuncture and oriental medicine, and  
14 the newly elected president of the American Association  
15 of Oriental Medicine.

16 Oriental medicine evolved into a systematic  
17 approach of triage and treatment through thousands of  
18 years of practice in both urban and rural settings  
19 throughout Southeast Asia. Through this evolution,  
20 oriental medicine developed into an ideal entry point for  
21 the provision of general health care services.

22 OM practitioners can provide basic assessment

1 and diagnostic services, acupuncture, herbal medicine,  
2 and manual therapy treatments, as well as make  
3 appropriate referrals and promote the continuity of care  
4 for each patient.

5 Our profession is recommending that the  
6 Commission encourage policies that will promote continued  
7 growth and development of OM in this country.  
8 Specifically, we support high entry level standards of  
9 training, such as the four-year, full-time professional  
10 doctorate program currently under development with strong  
11 core components in the biomedical clinical sciences.

12 We support health care policies that will allow  
13 direct access to OM professionals in private clinics,  
14 hospitals, and integrated settings. In particular, we  
15 strongly support a change in federal policies to allow  
16 Medicare and federal employees' insurance to provide  
17 reimbursement for OM services provided by OM  
18 practitioners.

19 We support the adoption of new treatment codes  
20 that will allow for proper tracking and reimbursement of  
21 OM services that are currently lumped under two codes.

22 Further, we support the use of OM professionals

1 to oversee and conduct research into the best OM  
2 practices.

3 On a personal note, I find myself in a unique  
4 practice setting, which, I believe the Commission would  
5 find interesting. I practice alongside four very fine  
6 physicians at Thomas Jefferson University Hospital Center  
7 for Integrative Medicine, Philadelphia, Pennsylvania.

8 My clinic epitomizes an emerging model of  
9 medical practice in which allopathic, homeopathic, and  
10 holistic medicine seamlessly complement one another to  
11 fulfill the changing needs and expectations of the  
12 health-conscious American public. In this setting, I am  
13 allowed to practice the full scope of OM without fear of  
14 criticism or being relegated to an inferior position in  
15 the clinical setting.

16 Currently, I participate as an equal partner in  
17 the clinical setting, research projects, and peer-related  
18 education of other health care professionals within the  
19 hospital community. Our hospital would welcome a visit  
20 by the commissioners, if you are interested.

21 We would like to be assured that oriental  
22 medicine is formally recognized and addressed as a whole

1 medicine by the Commission, and not simply divided  
2 arbitrarily into its modalities of delivery. We argued  
3 this point among ourselves years ago and we determined  
4 that the best moniker for a complete medicine is the use  
5 of the term "oriental medicine."

6 While based in traditional Chinese medicine, it  
7 has become a broad and diverse practice throughout  
8 Southeast Asia, and the term "oriental medicine" is  
9 pervasive in our field. It does not refer to ethnicity,  
10 but rather to a unique culture, history, and philosophy.

11 Finally, the Commission is encouraged to view  
12 OM as an effective system of medicine that can  
13 potentially lower the cost of basic health care and allow  
14 our thinly stretched health care system to serve more  
15 Americans, and to serve them better. Thank you.

16 DR. WARREN: Thank you very much, Mr. Cyrus.

17 Dr. Rutenberg, American Academy of Medical  
18 Acupuncture.

19 DR. RUTENBERG: The American Academy of Medical  
20 Acupuncture is committed to making medical acupuncture  
21 safe, effective, and accessible to an informed public.  
22 Medical acupuncture is an important complement to

1 traditional physician practice. Precedents have been  
2 established that --

3 DR. WARREN: Turn off one mic on the table,  
4 please. There you go.

5 DR. RUTENBERG: It is in the purview of the  
6 Medical Specialty Society to determine the course of  
7 study and clinical expertise for its members to achieve  
8 proficiency. Credence for this is found in hospitals  
9 privileging physicians to practice acupuncture and in  
10 state laws granting physicians the right to practice  
11 acupuncture under the scope of their license.

12 The AAMA's 2000 members residing in all 50  
13 states are dedicated to creating a uniform voice among  
14 acupuncture providers immune to interprofessional  
15 politics and special interest groups. Our goals include  
16 education of physicians, peers, and the general public.

17 To this end, we publish the Journal of Medical  
18 Acupuncture and the Acu-Briefs website, respond to local  
19 meetings in a national annual symposium, but more  
20 importantly, as people trust their physician to be the  
21 primary source for health care information, Western  
22 physicians will open the door to CAM therapies for most

1 of America. Physician practice of medical acupuncture  
2 will increase access to holistic coordinated medical  
3 care.

4 The health and safety of the public must be  
5 ensured. Recently published outcome measures document  
6 that only 43 adverse events in over 34,000 acupuncture  
7 treatments by physicians, and none were considered  
8 serious.

9 Congruent with health and safety is appropriate  
10 training. Based on the 1999 World Health Organization  
11 Guidelines on Basic Training and Safety in Acupuncture,  
12 one criterion for full membership in the AAMA is the  
13 completion of a minimum of 220 hours of formal medical  
14 acupuncture training in a program that meets AAMA  
15 standards. These guidelines are endorsed by the World  
16 Federation of Acupuncture and Moxibustion Societies, and  
17 have become the international standard.

18 Last year, the British Medical Association  
19 Board of Science and Education published its  
20 recommendations calling for a core curriculum for  
21 practitioners, including aspects of anatomy and  
22 physiology, research methodology, acupuncture techniques,

1 fundamentals of orthodox diagnosis, and ethics.

2           Graduates of American colleges of medicine and  
3 osteopathic medicine whose training in acupuncture meets  
4 the AAMA standard have more than satisfied this core  
5 curriculum.

6           Furthermore, every three years members must  
7 complete 50 hours of approved continuing education.  
8 Diplomats of the American Board of Medical Acupuncture  
9 must have an additional 100 hours of formal training, a  
10 minimum of 500 patient treatments, and pass the ABAMA  
11 examination.

12           The BMA/BSE stated there are a variety of ways  
13 in which acupuncture can be taught and practiced. A  
14 certain amount of diversity is healthy. The Information  
15 Age has created new models of remote education applicable  
16 to selected aspects of medical acupuncture training. The  
17 demand and need for evidence-based medicine is  
18 inescapable.

19           Physicians trained in medical acupuncture  
20 presenting and publishing research based on sound  
21 scientific principles and national medical meetings and  
22 in peer review journals are making believers of Western-

1 trained physicians.

2           It is my hope that the Commission will adopt a  
3 philosophy that neither rejects conventional medicine nor  
4 accepts alternative medicine uncritically and recognizes  
5 that good medicine should be based in good science,  
6 inquiry-driven, and open to new paradigms.

7           Endorsement of medical acupuncture by this  
8 Commission will create a cadre of physicians who will  
9 bring acupuncture, and by association CAM, into our  
10 medical centers, into our medical school curricula, and  
11 to our patients. Thank you very much.

12           DR. WARREN: Thank you very much, Dr.  
13 Rutenberg.

14           Dr. Coeytaux, How do you pronounce your name?

15           DR. COEYTAUX: "Remy Co-ee-toe."

16           DR. WARREN: "Co-ee-toe"?

17           DR. COEYTAUX: Michele got it just right.

18           DR. WARREN: Medical Acupuncture Research  
19 Foundation.

20           DR. COEYTAUX: Thank you.

21           Hello. I represent the Medical Acupuncture  
22 Research Foundation, and my goal today is simply to

1 highlight the potential role that non-profit  
2 organizations may play to help the Commission achieve its  
3 objections.

4 I have read most of the transcripts of your  
5 previous meetings and I was particularly interested in  
6 the statements from Drs. Leon Rosenberg and Steven  
7 Strauss regarding what the NIH can and cannot do to  
8 promote and support CAM research.

9 I believe that professional organizations and  
10 foundations can supplement the efforts of federal  
11 agencies by fostering innovation at the grassroots level.  
12 Successful foundations usually know the needs of their  
13 people that they serve, they can respond quickly to new  
14 challenges, they can identify the right people to address  
15 those challenges, and they can provide appropriate albeit  
16 limited resources.

17 In the case of research, foundations can help  
18 investigators develop research ideas and gather  
19 preliminary data to help them obtain funding from, say,  
20 the NIH. I have submitted to the Commission a one-page  
21 document. It describes some initiatives that may be used  
22 as examples of contributions that can be made by the not-

1 for-profit sector.

2 I would like to highlight the Acu-Briefs  
3 project, which is sponsored both by the American Academy  
4 of Medical Acupuncture and our foundation, currently. We  
5 are actually affiliated with the AAMA. This Acu-Briefs  
6 project is a website that features an extensive  
7 bibliography of acupuncture research. This project could  
8 be replicated for other healing modalities.

9 You may also be interested in a symposium that  
10 we are organizing in collaboration with the Society for  
11 Acupuncture Research to bring together CAM and Western  
12 medical leaders.

13 In sum, I support the Commission's fourth and  
14 fifth recommendations that were stated in the November  
15 16th draft that recommend collaborative support by non-  
16 profit sectors and encourages the creation of novel  
17 funding partnerships to augment federal agencies.

18 I encourage you to place a high priority on  
19 these recommendations. If followed and supported with  
20 sufficient resources, they will help the Commission  
21 achieve its objectives not only related to CAM research  
22 but also to many of the major issue areas that the

1 Commission is addressing.

2 I would like to add that, although my  
3 perspective on this matter is influenced by my role as a  
4 board member for a CAM-related foundation, I also speak  
5 as a CAM researcher. I am a family physician, and I will  
6 soon complete my dissertation in epidemiology based on my  
7 research on clinical trials of acupuncture and the  
8 control groups that can be used in those trials. I am  
9 also the principal investigator of two research grants  
10 that are currently under review at NCCAM.

11 I am sincerely grateful to those of you in this  
12 room who have made it possible for young researchers like  
13 myself to choose and to forge an academic career like the  
14 one that I am pursuing. I would like to thank you very  
15 much.

16 DR. WARREN: Thank you.

17 John Borneman, National Center for Homeopathy.

18 MR. BORNEMAN: Good afternoon. The National  
19 Center for Homeopathy would like to thank you all very  
20 much for allowing us to speak this afternoon.

21 I think there might be some notoriety in going  
22 last. I don't know that.

1           As the Commission nears the end of its work,  
2     the National Center for Homeopathy would like to take the  
3     opportunity to offer some perspectives on the role that  
4     homeopathic medicines may play in the future of American  
5     public health.

6           As you are aware from previous presentations,  
7     homeopathy is a system of medicine that has been actively  
8     practiced for nearly 200 years and in the United States,  
9     whose medicines are regulated by the Food and Drug  
10    Administration. Homeopathic medicines have been used to  
11    successfully treat both acute and chronic illness,  
12    including both epidemic and infectious disease for  
13    decades.

14           A growing consumer demand for homeopathic  
15    medicines has made their availability nearly universal in  
16    the United States, and yet there has been little done to  
17    create an effective partnership with the government to  
18    improve the state of homeopathic research, disseminate  
19    technically correct information about homeopathic  
20    medicines to medical professionals and consumers, to  
21    promote education in medical institutions, and to  
22    integrate the useful aspects of homeopathic medicine into

1 the American public health model.

2 For these reasons the National Center for  
3 Homeopathy recommends to the Commission the following  
4 steps: improve communication between government and the  
5 existing institutions in the homeopathic community,  
6 including the American Institute of Homeopathy and the  
7 Homeopathic Pharmacopedic Convention of the United  
8 States.

9 Second, create partnerships between government  
10 and homeopathic researchers interested in mechanism of  
11 action, basic science, and most importantly, infectious  
12 disease research. These partnerships could be as simple  
13 as adding homeopathic arms to protocols under existing  
14 study.

15 Third, facilitate the integration of existing  
16 homeopathic interest infrastructure including the  
17 American Institute of Homeopathy and the National Center  
18 for Homeopathy in the health care delivery system in  
19 order that homeopathy's useful elements can be employed  
20 to the country's benefit in time of national crises.  
21 These benefits may include the use of homeopathic care in  
22 trauma, post-traumatic stress disorder, and infectious

1 disease.

2 And finally, increase the public awareness of  
3 homeopathy, including what it can and it cannot do.

4 While these recommendations may seem simple, it  
5 is the view of the National Center for Homeopathy that  
6 homeopathy is an underutilized resource in American  
7 health care. It is our opinion that with proper  
8 partnerships with government, potentially with a higher  
9 level office, aspects of homeopathy can be used more  
10 efficiently to substantively benefit the American public  
11 health.

12 For the Commission's benefit, appended to my  
13 written comments are a 1907 report discussing the  
14 successful use of homeopathic treatment for a smallpox  
15 outbreak in Iowa, and additionally, comments made before  
16 Representative Burton's Committee on Government Reform,  
17 on November the 14th of this year. Thank you.

18 DR. WARREN: Thank you very much.

19 Commission members, do you have any questions  
20 for our panel?

21 [No response.]

22 DR. WARREN: Well, I have got some. Might as

1 well. I am the chair now, right? Okay.

2 Dr. Hemley, I appreciate your concerns for the  
3 species. I am a hunter and I use everything that I  
4 harvest. I was in Africa this year. The black rhino is  
5 a beautiful animal. For \$30,000 trophy fee you can dart  
6 a black rhino, get your picture made with it, and let it  
7 go. I think that is absurd because there is always a  
8 danger of losing one of those beautiful animals and there  
9 are not very many of them in the world. I appreciate  
10 them.

11 I don't know. I was editorializing? Okay.

12 For our acupuncturists on the panel, we have  
13 heard a lot of testimony from different groups of  
14 acupuncture, and it just baffles me. When are we going  
15 to hear one voice from all the acupuncture positions so  
16 that we can then include it into funding? It seems like  
17 we have five separate voices that need five separate  
18 insurance codings to get five different types of payments  
19 for the same procedure. When are you going to sit down  
20 at the same table and communicate with each other? This  
21 is getting a little bit absurd.

22 Comments?

1           MR. CYRUS: I agree with you. We are in  
2 agreement on that fact. As a matter of fact, October of  
3 this year the five organizations that you mentioned met  
4 and decided to form a steering committee to investigate  
5 the feasibility of creating a structure to provide that  
6 united voice.

7           DR. WARREN: You just made my day.

8           MR. CYRUS: You have made mine, too.

9           DR. RUTENBERG: Could I add to that?

10          DR. WARREN: Yes.

11          DR. RUTENBERG: The American Academy of Medical  
12 Acupuncture, despite the fact that David Maloney  
13 testified here that they were going to have an open-door  
14 policy, was not invited to attend and join in that  
15 coalition to form a steering committee, and we were  
16 disheartened by that and would be more than excited to be  
17 invited to join the next meeting.

18          DR. WARREN: Go ahead.

19          DR. COEYTAUX: A challenge.

20          DR. WARREN: I love it.

21          DR. COEYTAUX: Lay down the gloves.

22          DR. WARREN: I love it.

1 DR. COEYTAUX: On another front, I will give an  
2 example of what I see happening more and more often in  
3 the research world. Those studies that I mentioned that  
4 are under review right now at the NCCAM both involve -- I  
5 myself was trained through Joe Helm's course, a medical  
6 acupuncturist.

7 All the actual acupuncture treatments will be  
8 designed and performed by licensed acupuncturists, so the  
9 treatments themselves are more traditional Chinese  
10 medicine and yet it shows an example of collaboration in  
11 the research world, all of which occurs at the University  
12 of North Carolina with very good collaboration. This is  
13 not one, but there are many other examples of this type  
14 of collaboration.

15 DR. WARREN: I am so pleased to hear this. I  
16 have worried about this since I first heard the five  
17 groups talk together, and it has really bothered me --  
18 the same with the chiropractic world -- why we couldn't  
19 get all the organizations to come together and bury the  
20 hatchet and come up with one voice so we can get this  
21 thing moving. I love it.

22 Dr. Borneman. One more, Effie, and I will

1 quit.

2 Is there a homeopathic substitute for  
3 vaccinations available at this time or will there ever  
4 be, do you think?

5 MR. BORNEMAN: We will deal with at this time  
6 right now. The answer is no. There is no evidence in  
7 the literature that homeopathic medicines can be used in  
8 lieu of vaccination. That doesn't mean that people  
9 haven't tried it, but there is nothing in the literature  
10 that indicates that.

11 Further, the Food and Drug Administration has a  
12 specific policy that discusses the use of homeopathic  
13 medicines for vaccination and in fact proscribes that.  
14 There has been significant dialogue between the  
15 Homeopathic Pharmacopedic Convention and the Food and  
16 Drug Administration on the issue, and there is general  
17 agreement in the community that homeopathic medicines  
18 cannot be used for vaccination purposes.

19 If you think about what homeopathy is, it is  
20 treatment of symptoms. So the reality is that homeopathy  
21 would be best implemented after an outbreak, for example,  
22 of an infectious disease to treat those infectious

1 diseases.

2           What is in the literature is tantalizing. I  
3 can't recommend that it be used right now, but the  
4 research needs to be done and the research probably would  
5 be inexpensive if added to other arms of studies.

6           DR. WARREN: Thank you.

7           Effie, do you have something?

8           DR. CHOW: Thank you all for being here. I  
9 appreciated hearing from Dr. Hemley about the wildlife,  
10 because we haven't had that subject up, and at the last  
11 meeting. This is our last meeting. I am glad this was  
12 part of it because I think that is a very important area.

13           I certainly am glad to hear what you folks said  
14 about the acupuncturists coming together, and we do, we  
15 look at the person from a holistic standpoint so we must  
16 practice holistically.

17           So, on a personal level and as a commissioner,  
18 we have had the concerns and so if we can help in any  
19 way, please feel that we are right there for you.

20           Congratulations on your new position.

21           MR. CYRUS: Thank you.

22           DR. CHOW: And thank you very much.

1 DR. WARREN: Any other commissioners?

2 [No response.]

3 DR. WARREN: Thank you all very much. I  
4 enjoyed these panels today. Thank you.

5 [Applause.]

6 DR. WARREN: Ladies and gentlemen, we stand  
7 adjourned. See you in February.

8 [Whereupon, at 4:52 p.m., the meeting was  
9 adjourned.]

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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.

SONIA GONZALEZ, Court Reporter