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01 -- WHCCAM Meeting Transcript, Volume II *5 Oct 2001*
02 -- WHCCAM Meeting Transcript, Volume I *6 Dec 2001*
03 -- WHCCAM Meeting Transcript, Volume II *7 Dec 2001*
04 -- WHCCAM Meeting Transcript: Volume I (8 am) *21 Feb 2001 [2002]*
05 -- WHCCAM Meeting Transcript: Volume II (7 am) *22 Feb 2001 [2002]*
06 -- WHCCAM Meeting Transcript, Volume II: Excerpted Transcript Portion: Access and Delivery of CAM *22 Feb 2001 [2002]*
07 -- Final Report *March 2002*

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WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

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Volume I

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Thursday, February 21, 2001

8:00 a.m.

Doubletree Hotel
Plaza Ballroom I & II
Rockville Pike
Rockville, Maryland

PARTICIPANTS:

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The Center for Mind-Body Medicine

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C O N T E N T S

P R O C E E D I N G S

[8:25 a.m.]

DR. GORDON: If we could have a few moments of silence, and perhaps in these moments we can recollect our friend and colleague, Bill Fair, who as you know died about a month and a half ago. If we can just sit for a moment quietly before we begin.

[Moment of silence observed.]

Opening Remarks

DR. GORDON: I would like to just say a couple of words about the process and then I want to give everybody a brief chance to speak, and then Steve will talk about our charge for the day.

This is the last meeting of the Commission and we have a lot of work to do. I have appreciated the conversations and the e-mails, and I know there are some significant concerns that a number of you have about different sections of the report.

I see our work here -- and we will talk about exactly how we are going to do it -- but our work here is really to see where we stand as a commission. Our charge is to serve the American people, to bring forward the

best possible recommendations regard complementary and alternative medicine, complementary and alternative therapies, and how the benefits of them can be made available to the American people, how concerns about them can be appropriately addressed.

So we have a very large task. There are a number of issues that are still on the table. I see if we all come together really in Bill's spirit, which is passion and compassion, critical thinking, a collegial way of relating, and a really firm commitment to do what is best beyond any specific self-interest that any of us might have, that we will come up with a report which we will feel good about, proud about as a group, and that will serve people of this country.

What we are going to do is to give an opportunity for everybody, we are going to go through each of sections, and we are going to actually give more time to the sections than is on here on the schedule right now.

We want to go through the sections and we want to hear very clearly what your concerns are about every section, whether it is concerns about text or concerns

about recommendations. We are going to put them up on the board. We have some flip charts up here, and Ken is going to be working those.

We are going to address those concerns and either we are going to see that we agree, and that will be clear, we are going to see that there are disagreements that we can work out, either work out in this meeting or work out in the next few days, but ones that are clearly workable.

So, for example, if there is a change in text and the direction is clear, that we can then come together, get the change in text prepared, and get it out to you, or we are going to see that there are some areas where there may have been long-standing disagreements and we just haven't gotten over those disagreements, and we may have to let some of those recommendations go.

Our preference is to come together as a commission and to come together on what we do agree on, what we do feel good about, what we do feel is in service to the highest good of the American people, and to let go if there are areas where we don't agree, to either say so in the text, which is fine, we are not compelled to agree

on everything, and if there are areas where recommendations need to be scrapped, we will scrap the recommendations.

We would much rather do this and come together than issue a minority report. If there are truly irreconcilable differences, and we can't let some of the recommendations go, we may have to have a minority report.

But I think my preference, and I have heard from virtually everyone, as well as from those who are familiar with the way commissions work, is we are far better off if we can be strong and solid about what we all feel good about than to have a minority report and to have the report splintered.

So that is what I would like to urge us all to do and to rise to that occasion with respect for the differing opinions and with an understanding that this is, as Joe Fins said to me earlier, this is a rare opportunity that we have to make a difference.

Steve and I and some of the staff met with the staff of the Secretary of HHS the other day, and we have very strong interest in our work, a very strong

commitment to some of the basic positions that we have taken, and we are in a position to move forward, and we want to move forward together.

Now, we asked Max Heirich to come in and help with some of the rewriting sections. I am sure most of will remember Max from the very interesting presentation that he gave at the Commission. He has worked on national commissions before. He has been an observer of this movement for some 30 years, and teaches at the University of Michigan Medical School.

I think he can be very helpful. So in addition to whatever comments you make here, if we have agreements about specific kinds of changes that we are going to make in the text, it might be useful if there are particular nuances or particular things you want included, to speak with Max. He will be around for the next couple of days, and he will be available to help Steve and me and the staff on the rewriting.

We are going to be having lunch together today to talk about some administrative matters. We are going to go through until 6:00 today. I hope that is clear from the agenda.

We are not going to focus on either the vision statement or the executive summary in this meeting because, for me, as I was preparing the vision statement and I realized that there were still so many issues and contradictions out there, I felt I really needed to wait until after I had heard everybody at this meeting, and then I would prepare it and send it out.

Steve did a very long draft of the executive summary, but had a very similar kind of feeling, that we need to know what we are summarizing before we present the executive summary.

I would like to give everyone a chance if you would like to make a very brief comment because this is our last meeting.

George, do you want to begin? We will just begin from that side. If you have something to say, it would be wonderful; if not, that's okay, too.

DR. BERNIER: First of all, I think everyone has done a fantastic job in going ahead, and if we look back to where we were two years ago, it to me is an amazing happening.

The one area -- and it speaks up from a number

of different places and different subcommittees, but I have a great concern that we are labeling as complete and usable concepts and practices which have not been proven to be safe and efficacious.

That has been sort of a general phenomenon. I think some of the divisiveness that has come into the operation is really reflective of that. Now, I am not going to give you a page 12 change, but that is my concern.

DR. GORDON: Great. Thank you very much, George, we appreciate that, and we will go through the text and look at those places.

Linnea.

MS. LARSON: The only substantive thing I have to say is what I wrote out in an e-mail to all of you about the criteria which I have used to examine the whole document.

DR. GORDON: David.

DR. BRESLER: I have a lot of concerns about the report, and I guess we will cover them as we go through section by section, but what it seems to me is that as we go through this weekend, maybe what we want to

keep in mind is something we talked about in some of the earlier meetings, which is basically the posture of the Commission.

I think we agree that we didn't come in here with a basic advocacy position, and I think it is okay for us to be able to say we have studied these things, we have looked at it, we have taken testimony, and so forth, and here are things which everybody from various diverse interests agrees are recommendations that need to be met, and here are the ones that we could not find any agreement on and that need further study.

We may disagree on specific recommendations, but if we can create a report that we can all sign, which respects those disagreements, I think we are doing what you said, Jim, taking the strongest possible position.

DR. GORDON: Thank you, David.

Conchita.

DR. PAZ: I pretty much agree with that because it is hard to find people from such diverse backgrounds trying to agree on every single point, it is pretty difficult. I think some of these points of contention may be something that we are certainly going to have to

work our best with and see whether we can at least come to some agreement to disagree.

DR. LOW DOG: Not much to add other than I am pretty much in agreement with what has been said. I think that my main problem thus far is that we talk about the science being needed before integration can occur, we say that in the Research Section, and that we go on in the document to just sort of move right into integration on a lot of levels.

I think we need to take a step-by-step approach, so that the report is consistent. We are not saying these things should not be available, we are just saying that science needs to be done, research, which can include different outcome measures about patient satisfaction, quality of life.

I mean there is lots of ways to measure effectiveness, and then data about delivery, cost-benefit, et cetera, and then you move to integration, and I think it is backwards to integrate and then go do the research and see if it works. I just think that is a backwards posture.

The other thing is I hope that the Commission

really makes sure that instead of trying to leap too far ahead, we set the foundation for as the research becomes available, that there are ways to move this into the health care system, and that we have been very thoughtful about laying the groundwork for that as that comes available.

So set the stage for research and then set the stage for how do you move it from the research stage into the health care system.

DR. GORDON: Thank you very much.

DR. JONAS: I think that the report accurately reflects the area, which is one of great diversity and a huge number of constituencies that have different interests, different perceptions, and different views, and guess what - welcome to global medicine.

I think, therefore, we should go forward and emphasize two areas. One is being clear that our vision statement and our guiding principles are as compelling as possible and catch people's eye, and, number two, that the actual recommendations are as concrete as possible, and not vague, so that we can go back to them and say this is actually what we would like to do or we think we

need to do even if the recommendation is we need to do this type of research.

I disagree that research has to follow integration. It never does in medicine, never has, never will. It is a parallel process along with professionalization and various public interests, and this type of thing.

So I think we should move forward with the report and try to address those issues.

DR. GORDON: Thank you.

Charlotte.

SISTER KERR: I have a general statement, and I just feel very confident that we can clarify and come to some reasonable consensus on all of these issues in order to offer a new vision of healing and vitality for America.

DR. GORDON: Thanks.

DR. PIZZORNO: I think there are three points I would like to make. First, I think we have made a lot of progress, and I thought Wayne was elegant as ever, and that is, this is a challenging area. I think we need two more meetings, frankly, to resolve things, because I see

each time we get closer and closer to resolving our understanding. We need two more meetings.

Second, I think that there has been one fundamental problem with our whole process, and that is a lack of a good taxonomy for CAM. I think many areas we have run into challenges where we have had disagreement is trying to apply a fairly consistent standard to an incredibly diverse group of practices ranging from professional CAM practitioners with a high level of training and some science, to those with no training whatsoever, and not much science, and trying to apply the same standards to all of them, I think is not working very well.

Third, when I read through this document in total, in the airplane over here, I was impressed with what we had, and I think we make one major mistake, and that is, we put the Wellness Section first.

The reason I say that is because while I think wellness is important, I think in the Wellness Section, we are making much stronger recommendations for integration than is justified by the research, and I think that once you read that section first, it then

taints the whole rest of the document.

Again, I think it is well written and I think we have done a lot of good work on it, but it is not the right piece to do first. As a matter of fact, I would even say it should be an appendix.

It is not on our list of topics we are supposed to do from the presidential appointment, and I think it really has confused the whole issue. I think if you read the document with that as an appendix, I think it comes across as a much more balanced and appropriate approach.

Thank you.

DR. GORDON: Thank you, Joe.

Joe.

DR. FINS: First of all, I want to just say personally just how much I have really enjoyed getting to know everybody on the Commission, the friendships that have evolved, I think are going to be life-long, and to me, that is the most important and enduring outcome from a personal perspective.

I also want to just thank the staff and Steve, and all you guys sitting here with the back benchers for all the amazing work that people did under a very

difficult set of circumstances. I am sure many times it felt like you were trying to herd cats. I say that as a dog lover.

But I also want to just say that I have some concerns about the report. I said to Jim that I think that there is this opportunity, but I think we were starting with so much diversity on the panel that it was very hard to maybe realize all that, but let me make a few points, and I will think we will say more as we go forward.

I think there are many recommendations in this report that were made before there is adequate evidence to make those recommendations, scientific evidence or need, and I think if we take a public health perspective, it is not clear that the recommendations will promote the public health.

I agree with Wayne that medicine historically has been based on anecdotal evidence and accretion of information, but there is this trend towards evidence-based medicine and its new standards.

I think the report in many regards perpetuates the antagonism between conventional and CAM practice as

if there were two silos that were impermeable because there is a membrane between them, but patients move back and forth, and we have adopted a stance about two competing systems, and not a patient standard approach, which might be a focus for consensus and more agreement.

Patients move back and forth. They use these two modalities and two systems freely, and yet we kind of perpetuate the split in many regards editorially and elsewhere.

I think that there are some things in here that are just problematic on the face of it, government funding for industry, grants to industry, so they can pursue their own profits. I think that it is vague editorially.

There really often are no hierarchies of priority setting, no specificity. We talk about CAM this and CAM that, and as Joe Pizzorno said, you know, which CAM, which practitioners.

There are category mistakes, misuse and disingenuous use sometimes of the data, saying 83 percent of patients use CAM when they have cancer, while probably upwards of 95 to 100 percent use chemotherapy, and the

scope and the dimension of the use of one far exceeds the use of the other.

Things like spirituality and prayer are counted as a use of a CAM modality. So there is kind of CAM creep throughout the report.

Also, there is no mention as far as my close reading would suggest that the use of supplements has gone down, that Americans want more regulation vis-a-vis the Blendon Report. You would not know that from reading the report.

I think the issue of scarcity is another issue. This commission was initiated at the time we had no deficits, we weren't at war. There was a lot more economic enthusiasm and optimism, and I think we have to really talk about this report in the context of that.

Things like, you know, sort of tax breaks for insurance for CAM without a clear economic understanding of the implications and what we are sacrificing is a problem.

Two more points, Jim.

The other thing that I want to just say that I find troubling is any kind of equivalency by saying that

primary care is primary care simply because we label it as such.

Family practitioners, internists, I would add. Congress recently said that chiropractic was not primary care. Primary care means something, it's a discipline, and to say that Americans can be treated equally as well with others who are not trained in the primary care disciplines, I think disserves the American citizenry.

It is not to say that CAM practitioners don't have something to add.

I just want to summarize by saying that I think there is this opportunity, but I think that the focus should be a patient-centered focus, not an advocacy position for one field or another, and we should try to have a more integrative tone and less antagonism.

So thank you for that opportunity.

DR. GORDON: Thank you, Joe. Thank you for all those thoughts.

Julia.

MS. SCOTT: I agree with several of the comments around the table, although I will have to say I think I agree more with the assessment that Wayne

provided.

I want to also admit to the fact that I was a very active partner in the telephone calls and the whatever, so I think I bear that responsibility for what I am not happy about in the report, but maybe it took seeing it all together to really kind of bring that to fore.

I won't repeat what other people have said, but maybe I will just try to say maybe two things that I am troubled by and would like to work towards reconciling for me at least. I do think there are way too many recommendations, that I do think we have to be tough and really winnow down and think of what it is that we think is important.

I think we have an opportunity to be bold, and we should be bold. It is not like we expect all of this to happen tomorrow or next week, but I think where it needs to be said, it needs to be said. So I still feel very strongly about that.

The other think that troubles me is that we seem throughout the report to be constantly using the medical model as to what it is that CAM should do, and I

know it is expedient, and it's political, and that's the way things are, and people expect that that is the way things should be, but quite frankly, there are a lot of people who have not been -- large groups of people who have not been served well by this model, and I think CAM offers an opportunity, not withholding, we want safety, we want choice, and all of that.

I think that we need to be bold, and I will just stop there because other people have said it.

MR. ROLIN: Thank you. I, too, just want to commend the Commission for all the hard work that has been done. Certainly, it has been a joy for me to be a part of.

I concur with the statements that have been made earlier by the Commission members, but just a couple of concerns I have here. Number one is, as Julia said in her comments, the recommendations, of course, we have established guiding principles that we need to adhere to, and I am wondering if some of these recommendations may have gotten out of line in that area.

I can concur that in making these recommendations, we certainly need to be firm and bold

about them, as well, it is what we are recommending, that it just shouldn't be a listing. Concerns, yes, but we should really be concerned about that.

I, too, have concerns. We are talking about regulations and even the continuation in some form of this commission, and is the American public ready for that, and especially since what has happened in the last three months, four months here, is our nation, a nation thinking in terms of health care.

Yes, I think they are, it is a primary concern, but then they have got these other issues to deal with. In line with that, I am thinking in terms of this report and how are the states, how are they going to really utilize this report in dealing with the people who need care. I go back to the access issue which we dealt with, so I am really concerned there.

This, to me, is very serious, and I just wish that we had a little more time perhaps to really, as Joe has said, I really enjoyed reading this report. It is amazing when you stop and read it how much work has been done, but then you realize that there are certain areas that there are questions that you have.

So those are my general comments. Thank you.

DR. WARREN: Well, I sat down yesterday and talked with my staff at the office about really what are we trying to do here. We were brought together, not because -- well, it was a presidential thing -- but because of consumer-driven interest.

I don't know that we would have this commission at all had the report not come out there was $14 billion spent on CAM. I don't think we would have this commission. I think it is basically financially driven.

It is a process that the public wants, the public has shown the interest in it. They are going to continue to show the interest in it. Suddenly, they want something, they get it, and they want Big Brother to take care of them. Most people don't want to take responsibility for what is going on.

I see our group here, yes, we are very diverse. I don't see a lot of people that try to understand the other man's position. I think we need this to be a win/win situation for everybody on this commission, and for the public, and for the Congress.

But we have to do, as people on the commission,

understand other people's position. Quit trying to persuade me to your position, learn to understand my position, and then let's move forward.

There is some good stuff in this report. Yes, we have too many recommendations, we need to cut it down, but there is a lot of good stuff here, a lot of effort has gone into it. This staff has done a fantastic job, and the commissioners have done a fantastic job, but this has to be a win/win or dump it.

I think the next two days we need to win/win or get rid of it. That's all.

MS. GUTIERREZ: I have two things. First, with the document in general, I think today's challenge is going to be to balance the fear of loss, which is the status quo, with the desire for gain, which I see as growth, knowledge, and consumer choice in the marketplace.

So I concur with Wayne and Julia, and other people around the table who quoted Beth Clay when she said be bold, this is our opportunity to do that.

My second item has to do with text, and I did notice that when I was reading short pieces together, but

reading through as a flowing document, we use the word "should" dozens and dozens, maybe hundreds of times, and I don't think it is our place to tell Congress what they should do. When our children were growing up, we told them you can't should, you either do it or you don't do it, you either act or you don't act.

So before we proceed through the document, I would like to suggest that maybe we strike the word "should" and emphasize the action verb in all of the recommendations and action steps.

MR. CHAPPELL: I am grateful for all of you, everyone, for what you have participated in and contributed, and I am pleased to have been part of this.

For me, the work we are involved with is a journey, and this commission is not an event, it's part of a journey that will go on, and we are not going to solve all the answers, and we are not going to complete all of the hopes.

So I would like to enter these next two days with a, oh, for myself, a little more sense of humility, that we are here to make progress on this journey, and not try to bring about a kind of perfection to everything

that our minds would like to have.

So with progress in mind, I feel that, as Don has said, we have got to decide individually where are the areas that we can let go of for the name of progress, for the sake of progress, what can we let go of that simply isn't that important in the bigger picture of progress.

There are some things we won't be able to agree upon, but I don't think that is the subject of the report. I think that is stuff that is left on the roadside. I think the report should be about our common advocacy, what is it we agree upon, how is it we are contributing to the road of progress.

So, for myself, I am here to let go of the things that I can for the sake of progress, and to just let the roadside collect the stuff that we can't agree on for a future group, a future day.

Professionally speaking, let me tell you that the marketplace is unforgiving. That is the one thing you can count on. We don't have to trust in just ourselves. We can trust in the consumers. They are unforgiving. They will get what they want when they want

it.

Our job is to try to enhance their ability. That is why we are formed, enhance their decisionmaking with good information, access to better information, and they are really not going to be concerned about professional issues that we have.

I am personally going to proceed these next two days with a sense of what it is I can let go of, what it is I can contribute for a document of positive advocacy, common advocacy, and progress in a road and a journey much longer than March 7, 2002.

DR. CHOW: Good morning. I want to say just really how grateful I am to have all the diversity influences on my life with this commission.

The Commission was set up because of demands of the people and because there was a recognition that there was this diversity and that there was unhappiness with the system as it was.

I think we have to keep that in front of us, that we are here, not representing ourselves and our own views, but we have had nearly 1,000 people and more than that writing in, and we have been hearing, and that I

don't think there is any problem with disagreeing with each other, with respect, and stating where the disagreements are.

I don't even want to call it "disagreement," the diversities, and make it a positive aspect, because that is where growth is, and that is why we are here.

So I would like to acknowledge that there will be things that we agree upon, and then the things that we don't have consensus about, not to portray it as a negative point, but it is a very positive point, because that is what is happening out in the field.

Wayne said some of the things that I thought, and Julie, and Joe, that I don't think we should be afraid of having different opinions, and that we should state that in our document, and that it is one step towards the long mile, and we are only that, just like this life is only one chapter of many lives.

So, therefore, I think we need to think more than the Commission, I think we need to represent what has been testified. We need to represent the divergent field, not really be stuck in sort of saying that there has to be one way.

I think if we look at things positively, I think we can overcome what we are fearing about, in all our conversations, that we are not reaching a consensus. I know there is one consensus, that the Center needs to be done, and to carry on the work which the Commission has begun.

It is just another step. AOM and NCCAM, we went through the same process, we couldn't accomplish as much as we could, and it's moving on.

I think with that attitude, I think we might be able to come together and feel better about the report and that you are not signing the report because it is the end-all and be-it-all document.

The list of the people at the end of our appendix is phenomenal, and you think you are going to get consensus from all of that? I really appreciate all the work that has been done, and like Joe, I want to thank the staff, too. It is really a muddy water that you have been wading through, and with all our different personalities and everything, it really is great where we have come.

If we only put it on a positive vein and be

courageous about stating the diversity, and not look at it as a fault, and I think that is what we have been presenting it all the time. That is what I am troubled about.

Thank you.

DR. GORDON: Thank you, Effie.

Don, you wanted to add something?

DR. WARREN: I was just sitting here thinking. We were brought together by the President, and his charge was to be an advocate. It seems like all of our four points that he gave us were to be an advocate.

I think we need to be reasoned and logical in what we advocate, but we are here to be advocates. We are here to tell the Congress, tell the President how to possibly go about integrating CAM into the nation's health care system.

I think we need to remember that. Don't be worried if we are going to step on somebody's toes, go ahead and step. We might make some enemies, we might make some friends.

DR. GORDON: Thank you. I really appreciate everyone having spoken. I want to just add that I think

that we have come a very, very long way. We have gotten to know each other in a variety of ways. We have come out with a number of different perspectives. We have covered a huge amount of territory. As Effie says, a thousand people have testified, more than a thousand more have submitted written testimony.

I want to emphasize something that Don said as we go ahead with this discussion. This is not about argumentation. This is really about listening and about respect, and trying to come together to the highest place, whether it's agreement or disagreement, in the service of the people, not in the service of narrow interests or any of our particular foci. I think all of us have to be called to this higher work.

The other thing I want to ask everyone to do, since this is our last meeting together, is please, put on the table the issues that you have. I think it is really important that if there is a significant concern, please state it, and state it directly and openly, and everybody take it in as this is this person's concern and let's see if we can deal with it in the course of our discussions.

It is important not to -- I feel sort of funny saying this -- not to hold back, because this is our time to really deal with any of the concerns that are remaining about the report.

I want to thank everybody. I want to thank the staff, as well as all the commissioners. Everybody has really worked very, very hard, and I think in a very collegial way. I am hoping we will continue these next couple of days and with any final work on the report.

Steve, do you want to speak specifically to the charge?

Charge for the Day

DR. GROFT: Other than those issues, we have got an easy meeting.

[Laughter.]

DR. GROFT: George DeVries is taking the red eye in from San Diego, and he will be here later, so when he gets in, we will give him an opportunity to address his position and thoughts, as well.

Dean Ornish is due to come in tomorrow morning and perhaps we can hear from him. I think he also sent an e-mail to all of us, or that you probably got or

didn't get during the night. We are going to get it copied and handed out to everyone.

I think he has some comments on some of the subjects that will be discussed today, as well, just to let everybody know what his thoughts and suggestions were as far as the report, but he will be here later this evening and again all day tomorrow.

It has been quite a journey, as Tom has referred to, our minds, bodies, and spirits, as I wrote in our note, and we have a lot to do. I think basically, the charge is to come up with a report that will reflect what the Executive Order asked us to do, and that is to provide recommendations to Congress and to the Administration.

I am not so worried about shoulds and woulds. I think this is something that any commission writes. They are asking for direction, how we express it.

I think even if you look, some of the earlier versions of the recommendations, we got rid of "The Commission recommends," and we tried to put in some action verbs. I think we will continue to do this as we go along whenever possible, and we will continue to

reduce as we go through the meeting.

I think that is something the staff is prepared to do. Again, I can't thank them enough. They have been great.

[Applause.]

DR. GROFT: Let me bring you some good news. First, Michele is doing relatively well. She has been confined to bed for the last three weeks, I guess. She was having some premature contractions and I said okay, you stay at home and work, so she is there.

We are going to try to link up with her tomorrow and just for the wellness discussion and everything. She did want to be here, and I know how much she misses you all and everything else.

We know what the charge is, what we have to do, and I think, looking at all of this, we are all pretty high achievers in our own respects. I look around at all of us, and I look at the audience too, over-achievers, I mean we are up there in the super category.

I think we always want to win, we always want to do what is right, and get it right. You know, we aim for perfection, and we are not going to get that, but we

are going to do something pretty good here, as we did back in 1991 and 1992, when OAM was started, and how we have moved from those days until where we are here.

Wayne Jonas was along on a lot of that journey. Many of you have been on the same trip, participating as consultants to the government, and leading the charge. Jim has been involved, Effie has, a lot of us have been around, I, more peripherally than everyone else.

The opportunity here is for us to give guidance, where should we go, how can we get this integration that everyone is looking towards. I agree, we don't want two separate systems, nobody wants that, but how can we best integrate the two systems, that we can give the best care to the patients that everyone sees.

I think we can do that. We are going to have to do a lot of rewriting. The staff knows this, they are prepared to do it. We have spent a lot of yours listening and talking, and I really appreciate all of your presence and contributions during those many hours when we were talking and trying to figure out what is it that we wanted to present.

I thank you. I don't know if you realize how much you have contributed to the report and how much your voice has been heard and has been inserted. I think if you read the report, you are going to see bits and pieces of everything -- not everything -- but many of the things that you stated, you are going to find in the report.

That is what we tried to do. We felt all along that, gee, we are not sure what it is that the Commission really wants. I think this meeting here, we want you to collapse it all and then to rebuild it, keep that which is really good, but so often we have to focus on the negative of what is wrong with the report, and that is okay.

There are a lot of good things in the report, and we don't want to forget those, but we do have to attack those that everybody is uncomfortable, so that when we leave here tomorrow night, there is a comfort level that this is a pretty good summation of where we think things should go.

As I have mentioned to you, I am continually impressed by all of your efforts, what you do in your own personal lives and how you contribute, and the diversity

of the group.

I look at where we were in July, around July 5th or so, when I started calling everybody and say, hey, we are going to meet July 13th and 14th, and everyone showed up. I mean they took late night flights, everyone came. It is amazing accommodation to do what we had to do, and even now we have remained strong to that end, doing what we have to do, and that is how I look at the meeting today and tomorrow.

We are going to get there. Just work with us and keep laying your feelings and your thoughts on the table, and discuss them. I think once we get your thoughts out, we can start to build that report that we need to go forth with.

It is okay to have difference of opinions. We can state that. Five years ago, people would say no, you have got to have everything right. That is not the way the Administration is working.

Everyone wants to hear options, and if there are areas of disagreements, we want to hear the areas of disagreements, so we can address those, so that when we finally do address each of the issues or when the parties

who are responsible for addressing each of the issues, at some point in time, whether it be April 20th of this year, January of next year, what have you, they will see that the Commission said this, and they recognized these problems, and I think that is the wisdom we are looking for from all of you, that collective wisdom.

We know there are problems here, we can address them, but we have to state what has to be done to keep things moving.

Thank you.

DR. GORDON: Tom.

MR. CHAPPELL: Thanks, Jim. Steve, thank you for your openness. I want to ask Steve if one style device or a shaping device for the document might be for us to create, in each section, something called "Central Issues."

I know that issues are either expressed or implied in the copy of the report, but sometimes the recommendations aren't able to hit the issue head-on, at least in an area that I am familiar with, they fail to do that. So, in a way, we sort of bypass identifying the real concern and issue of the consumer or the bigger

picture.

Example. What I am after with this idea is to try to capture the best of the hearing process, what did we hear out there. On safety, for instance, can we make a very clear statement that this is a huge issue, that our recommendations are not addressing head-on, but we are bypassing, our recommendations are bypassing the issue.

This is one area I am sensitive to, but I wonder if -- we have done everything else so well -- could each section have an identification of key issues in that category.

DR. GROFT: I think not only could we identify, but you create your hierarchy of issues, as well. So I think that is something we would welcome as we go through it, and I think that would help shape the executive summary, as well, if we could identify both the core issues, central issues, as well as the hierarchy of issues.

DR. PIZZORNO: Jim, one of the comments you made was that we can incorporate into the report, areas where there was not agreement. Could you explain more

about how we go about doing that, because I agree, it would be nice to have one report, and if we have some diversity, we could not figure out how to put it in.

DR. GORDON: If there is an issue -- I will make up an issue. Let's say lighting in this room. The majority of the commissioners felt that the lighting was quite adequate in this room, but other commissioners were concerned that artificial lighting might pose a health threat although the research evidence is not in on it.

Just coming off the top of my head, that is a way of raising the issue, and discussing the issue, and we can't say we absolutely have to have this lighting, we can discuss the pros and cons of having this lighting, and we don't really feel the evidence is finally in to decide whether we should have this lighting or bring in full spectrum lighting, something like that.

DR. PIZZORNO: So could there be a section at the end of each of the sections that says "unresolved issues," is that what you are thinking?

DR. GORDON: What I would like to do is to go through the report and see how we come, because I think it is going to be dealt with somewhat differently. We

may want to do that, and that is a perfectly good idea, and I am open to hearing from other people about whether or not that makes sense, but we may also not want to do that, because it may only be applicable or the unresolved issues may not be important enough for us to give that emphasis in the report.

I would rather see how we come out and then figure out how we deal with the material with that as an option.

Charlotte.

SISTER KERR: This is just input for how we would proceed. It is sort of a point of order. I foresee -- which I think is fantastic because it is saying we are still trying to burst forth with some new vision -- when we get into these points of lack of consensus, for example, I hear the one on primary care and the complementary medicine, and I think it is important, which everyone has said, you know, the honoring of the diversity, and so I am wondering, and I thought Tom might have a point on this, of when we identify either before, like if we listed the six things at the break of what we know are going to be kind of

issues we want to clarify or refine, if we could actually have a process built in, okay, here is the point, kind of an arbitrator or how would we debate it, so we get it out without just 24, you know, "I want to" speaks, you know, if there is anything we need to reflect on that for how to proceed when we hit a snag of a point.

DR. GORDON: I am open to any suggestions. My thought up until this point would be that we would bring out, let's say, a primary care issue as an issue, and we would just hear from people, keeping in mind the limitations of time, and that people, where your point of view was sort of where it exposed a crucial difference from the previous points of view, that it will be important to state, but it would not be important just to speak for the sake of speaking.

I think we need to be economical, we need to hear the different perspectives, and then we have to see where we are, and at the end of each point, we would then say, okay, how are we going to proceed, is this one of those things we have significant disagreement on and we need to address in the way that Joe was suggesting, is this one of the things where if we change it in a minor

way, we can get agreement, is this something where we agree, but the text just doesn't support, and so we ask the staff to help us get the text to support it.

I don't know how many issues there are going to be, I don't know how difficult they are going to be. I don't know that there is a uniform process for all of them. I would like for us to start going through and see how it goes, and then if it is working, great, and if it is not working, let's change the process.

Don.

DR. WARREN: What is going to be the criterion for acceptance of a recommendation by the Commission or rejection?

DR. GORDON: The thoughts that we had is that we would like at the end of each section, to see which recommendations we now accept.

DR. WARREN: Will there be a vote? Will there be a majority, a three-quarter?

DR. GORDON: I am open to the possibility. I think we have to see who is in favor. We will have some kind of vote. Most of the recommendations, most, not all, we have already had unanimous agreement on. There

will be some where we either haven't or where people have realized this really don't work for me, I'm sorry, and then we are going to have to revisit those.

But I think that we can indicate, and maybe with staff's help, we can reemphasize which recommendations there has been unanimous agreement on before, and maybe if each staff person in charge of the section can help us with that as we come up on those sections, and you can provide that for us.

I know some of the recommendations we went back and we said we want to work on it again. So, if there is something we have unanimously agreed on, that we are now going back on, I think we really need to focus on why we are doing this, and if a couple of people don't agree, we may want to say this is a recommendation and a couple of people have concerns about it, or we may want to take that recommendation out.

I think that is something we have to figure out when we come to it.

Effie.

DR. CHOW: I have trouble with rejecting anything because we can have total agreement, we can have

moderate disagreement -- oh, I hate that word "disagreement" -- diversity on it, or divergent opinions on it.

We brought out recommendations because it must have been brought forth in the testimony, and I still want to get to the fact that we are not representing ourselves. We keep talking about we voting what we feel like. It has come from the testimony of the people.

So, therefore, for it to be in our paper right now is because we heard it so many times. So even if we all disagree, it must have come up because of what we have heard.

So I am not sure that we throw out anything. I think we should categorize it that there is greater agreement with this, and then there is divergent feelings, and then there is this was brought up as an issue, an important issue, because at this point, throwing out something is just as bad as -- I don't know. I really feel we have gone through this report a lot, and we should have thrown it out before if, at this point, we needed to throw it out.

So, I think there is import to it.

DR. GORDON: Thank you.

Tierona.

DR. LOW DOG: I like the comments about divergent thinking and divergent opinions. I guess I still am having a little bit of problems with kind of the bias that we keep referring to as far as consumer-driven movements and the testimony that we heard, because there was a real bias in the testimony and the people who came, and even down to the invitations of people who were invited.

So I feel like we got a sliver of what the American public feels, but I don't feel like we heard from all walks and all peoples of all opinions. So for myself, it is not just the people who showed up, but all the other people in our experience.

We don't live in a vacuum. We all have our own interactions and interfaces with people. So I am hoping that for myself, that it is not just about just the people that I remember testifying, but all the things that I have read and all the things that I have heard and that I have written, so consumer-driven movement and testimony is one thing, but I think we want to keep in

mind that there was definitely a bias in what we have heard and to keep that in mind as we go through the report.

DR. CHOW: I agree with you on that. It is not just the testimony, but all of it.

DR. GORDON: Charlotte.

SISTER KERR: Mine again is just a point of order, which is separate from what we are saying.

When we speak today, Mr. Chairman, could we be sure we speak -- for example, when Max did his response for us, I am really confused on what has been called a chapter and when it is 3.1, is it 3.1 of Chapter 3, so if you could just clarify every time we start, so I can be right on-board. Like the Health and Wellness doesn't have a chapter title. Just so we can get that down.

DR. GORDON: I will, with assistance, do my best.

Tom.

MR. CHAPPELL: Thank you, Jim. I am concerned that if we just proceed with an arbitrary approach that we will see how we do, we will waste a lot of time. I wonder if, instead, you and Steve could come up with a

recommendation of how we are going to proceed, what is going to be the decisionmaking method as we proceed.

I think we would all benefit from a decision on that at the outset rather than along the way.

DR. BRESLER: Just to make things simple, what I think we should do first around is just simply say here is a recommendation, do we all agree. Great. If we don't, we agree to disagree about it, and then let's look at the camps that are disagreed about it, but I think the whole tone of the report is we agree with all these recommendations, and we agree to disagree about these particular ones.

I think as we go through it, I think we have great consensus on most of them, and I think we can get through a lot of it fairly quickly. There will be a half-dozen issues that will tie us up, but let's look at those.

DR. GORDON: There is also the issue of text that I want to make sure we address. I think in some instances, we will have much more agreement on the recommendations, and the text may need significant work. So we can if people would like, we can work back from the

recommendations to the text. Is that what you are suggesting, David?

DR. BRESLER: We can go that way.

DR. GORDON: Does that feel comfortable, Tom, as a means of working? Our initial plan was to go through the text and then look at the recommendations at the end, and then as we go through the text, see what issues there are, put them up on the board, and try to deal with them one by one after we have got the whole list of issues that need to be dealt with, whether they are in the text or in the recommendations.

DR. BRESLER: Jim, for the sake of time, though, I would like to be able to dismiss a lot of the things that we are in agreement with, and have them fine-tuned and wordsmith it, and focus our time on the ones that we really need to work on.

DR. GORDON: Okay. There is a recommendation from David, which I am assuming, if I am wording it correctly, is to deal with the recommendations first to see where we agree, and then to go through the other recommendations, and then to go back to the text?

DR. BRESLER: That is kind of the way I thought

you were going to go through the report that way, look at the recommendations, if there is consensus, see what concerns people have, then move on and focus on the ones where we have disagreements.

DR. LOW DOG: Let's try it as an experiment.

DR. GROFT: We are starting off with the introduction and the history, so there are no recommendations, so we essentially will be going through the text. So I would offer let's try that process first.

DR. GORDON: For now, let's go through the introductory chapters. Then, we will take a break, we will come back, and the next time we can go to the recommendations first in the next chapter, and see where we are. Okay? Let's see how that works. If it works well, great; if it doesn't, we will go back to a way of working through the text.

DR. GROFT: Perhaps at the break, we can talk about the procedures for gaining acceptance, whether it's a vote or a majority, or exactly how we want to go.

DR. GORDON: Let's take a look at the Introduction. Thank you, this is great. We are all working at this together. There is no divine answer that

we have received yet.

So let's work on the Introduction and begin with that, and then look at the text and issues. Ken is going to write up any concerns or issues about the introduction.

David, please begin.

Open Discussion: Introduction and History of CAM, Guiding Principles of the Commission

DR. BRESLER: I have a lot of problems with the Introduction. I think it misses the whole point of why this commission was formed. I mean anybody who is reading this is going to want to ask the question, "So what, and what does it mean to me."

The whole point is that there was concern about the use of complementary and alternative medicine, concern in both directions, concern that it represented low technology, low-cost alternatives that might be beneficial to the American public, and concern that there was a lot of unproven techniques that were in widespread use that could be dangerous.

I think that we have to justify the fact that there was a need for the commission, and that it is a

good thing that the commission was formed, not just in the executive summary.

DR. GORDON: Great.

DR. BRESLER: The other comment I would make is that I think the IOM report and the Healthy People 2010 report should be appendices, and refer to, and the emphasis is this is a major concern for the American people, this is why we looked at it.

DR. GORDON: Some of that was a mistake in the printing. All those details should not have been printed the way they were. That was a mistake. So thank you for that and thank you for your thoughts.

Other thoughts about this first introductory section? I am going to try to move through these as quickly as we can, we get agreement about these issues, then, we can go back and, in these sections, it is a matter of rewriting to conform to the general agreement that we have among us.

Joe, go ahead.

DR. PIZZORNO: In an earlier version of this, we had a lot of language that was kind of anti-conventional medicine politics, which we all thought was

too strong, and not it is totally gone from the document, and I am just appalled by lines 9 and 10 of the first page.

That implied the only reason that CAM did not develop was because it was not scientific. That is clear, part of the problem. Their problem was the AMA did everything it could to suppress this form of medicine. That has to be stated. That is a matter of public record.

DR. GORDON: Joe, how are you suggesting that be worded?

DR. PIZZORNO: Well, I think it should be worded gently, but it has to be stated. I mean clearly, there has been a century and a half of opposition by the American Medical Association to this form of medicine, we can't pretend that does not exist.

DR. LOW DOG: I am not sure where you are.

DR. PIZZORNO: The very first page, Introduction.

DR. LOW DOG: Where it says, "Until recently, the primary response has been" --

DR. PIZZORNO: Right. That's the only

statement about why it has not been more public. That is all that is stated.

DR. GORDON: Let's hear the issues and then let's see where we come out.

Tom.

MR. CHAPPELL: In the section following the guiding principles, we have a section on the National Academy of Sciences Institute of Medicine's report, Ten Rules for Health Care Reform.

It just feels odd to me -- okay.

DR. GORDON: I think we have agreement on that, and we are not going to have that in with that kind of detail. That is what I have heard, that is what was conveyed initially to Jim Swyers from the comments, and it just didn't get in. They just wound up being in this detail.

I think that the agreement that we had on this was it is important to mention the IOM and the congruence, but to have all the wording is not important in this section.

MR. CHAPPELL: Or it could be handled in an appendix, too.

DR. FINS: I agree with Tom on that, as well. I think it just kind of sits there and it doesn't necessarily follow, and it is too long, but I think there is something about that and why it is there that speaks to Joe's comment.

I don't think this is a report, Joe Pizzorno, to refight the old battles. I really think that we need to get beyond settling the old scores. I think that what we need to do is somehow upfront, Joe, talk about the need, and I think this is what the crossing the quality chasm reference is about, is meeting the needs of patients as they move back and forth through these two systems of care.

They are not served if that is two antagonistic systems or two competing systems, or we are fighting old, historical battles. So I think that the Introduction should be positive, and not accusatory in either direction and say, look, you know, there is increased use, people are living in both of these systems, and as long as there are two systems that are antagonistic and competitive and at odds, there is no cross-training, and there is no cross-education, that patients are going to

be ill served, and that is a threat ultimately to the public health.

So I think that should be the tone, and I think that is something that everybody can agree on, because, you know, Julie was saying this is for the people, this is patient centered. We have to serve the people, and we are not serving the people by going back and saying the AMA was this or the naturopaths were that.

I think we have to recognize that in many respects, those old scores were settled by the establishment of this commission. That is the vindication in many ways.

DR. GORDON: Okay. Any other comments on this introductory section? Joe, go ahead.

DR. PIZZORNO: Joe, I appreciate that we don't want to go back and fight old historic battles, I agree with you 100 percent, and today, right now, the American Medical Association, the state associations is blocking the licensure and economic equivalents of CAM professionals.

It is happening right now, so we can't pretend it doesn't exist. This is a real problem for the public

because what happens it when you block credentialing of CAM practitioners, then, the public is left with what is left out there, and it is a huge public safety issue.

DR. GORDON: I would like to suggest that there may be issues that need to be dealt with. I don't think the Introduction is the place to do that. I think that it is very important that the Introduction have the positive tone and that whatever historical or whatever present issues be dealt with as they come up in the text.

DR. PIZZORNO: I am fine with that.

DR. FINS: I think another point about equivalence is we are not equivalent. I am not equivalent to Joe Pizzorno, and he is not equivalent to me, and we all do different things around the table.

That is not to say that one person has more or less value than the other person, but I think the notion that to strive for equivalence, you know, misses out on the diversity of perspectives. So we shouldn't talk about one replacing the other, but what, in the aggregation, what kind of synergisms exist.

We are better off because, you know, there is a Joe Pizzorno and there is a Joe Kaczmarczyk and Joe Fins,

and all the Joe's, so I think that is what we really need to focus on, and I think if we try to have equivalence, in many ways it is disrespectful because it diminishes the value that each of us singularly brings to the healing equation.

DR. GORDON: Julia.

MS. SCOTT: I think the tension here is that we have been charged as a body to bring together in this report, differing views, and I think we are trying to bend over backwards to make this balance, so that we are not falling in one camp or the other, but at the same time, I don't think we can always just gloss over or remake history.

I think Joe's point is well taken. I don't agree that it belongs in the Introduction. I think lines 9 through 11 or 12 kind of says there was these kinds of barriers, but I do think in the history, we should point to it, not for pages and pages, but I think we can't rewrite history, we can say this is the way it has been, but this is what we have heard from the public on where we want it to move to the integration.

DR. GORDON: I am going to keep on taking a

role that is not unaccustomed, which is to move discussion forward with everybody's consent because we have a tremendous amount of material to go through. I want to focus here on the Introduction and get some general feeling, which I think we are coming to, and we can address some of the other issues later.

Wayne.

DR. JONAS: I am wondering if one way to make a bold statement and also keep it very positive is to try to formulate a vision of what we want we want to see, what we want to accomplish in this field, as we have discussed several times.

I know that was something that I think was said was coming and we were going to deal with it, but I am wondering if that isn't an approach that would be useful.

DR. GORDON: I think that what is happening is that aspects of the vision are emerging from this discussion, that it is there, and that that will be presented, but that the diversity is important, that the positive tone, that the collaboration is part of that vision.

DR. JONAS: When will there be an opportunity

to kind of review such a statement?

DR. GORDON: Once we finish this meeting, and I have a clear sense of where everybody is, I will send it out to people within a day, two days -- within two days

MR. CHAPPELL: I am wondering if the term "Introduction" would be better the Commission's charge, because that gets right to the nub of the point. Then, you can take out any attempt to try to approach this topic, and that is what is going on here.

The Introduction is trying to approach the topic, and we are going to have differences of opinion about how to approach the topic, because other content is in history or guiding principles.

Why don't we just name it? Let's call this, instead of Introduction, this is the Commission's charge, and then you have got history and guiding principles, and I think it just allows you to clean up --

DR. GORDON: So what you are suggesting is Commission's charge together with guiding principles?

MR. CHAPPELL: Well, you have got really three segments. You have got Introduction, History, and Guiding Principles. Instead of Introduction, I would

rename that the Commission's charge.

DR. GORDON: And where would the Guiding Principles go?

MR. CHAPPELL: It would stay in the order that it is. All I am trying to do is in the report, where you have the section called Introduction -- oh, I see, the Introduction is embracing all those three segments, the Charge, the Principles, and the History. Is that right?

DR. GORDON: The History is the second chapter. What I am hearing you say is that in the Introduction should just be the Charge and the Guiding Principles, or just the Charge?

MR. CHAPPELL: Just the Charge.

DR. GORDON: And then the Guiding Principles should be part of the Vision?

MR. CHAPPELL: No.

DR. FINS: Make that a separate section, Tom?

MR. CHAPPELL: I would leave History and Guiding Principles in their current sequence. I would just change the name of the title Introduction to the Commission's Charge, and then I would clean up all of the little sensitivities about how we found our way for this

charge to be created.

We don't care how the charge was created, it just was, so let's say that, and then we avoid Joe's and Joe's discussion at this point.

DR. FINS: I agree. The charge is really the Executive Order. We should ground it in the Executive Order.

MR. CHAPPELL: Fine, the Executive Order.

DR. FINS: And talk about the Executive Order and review that. What we ran into in the July story, you know, our July meeting, we had those two or three days, and we had a much more ambitious, you know, verbose report, and we trimmed it down, and less was actually a hell of a lot more.

I think Tom's editorial suggestion is a step in the right direction. I would make another suggestion that I think might really help us link up the text with the recommendations, is to have very brief introductions to each of the sections on the order of a page, like kind a real tight abstraction of what we need to achieve, and then have each of the recommendations followed by a supporting paragraph or two.

This will help the writers because we have a short time frame. It will be able to explain why we are making that recommendation. If we can't support it or we see that it is a redundant recommendation, we will lose the recommendation, and it will help decrease the number of redundancy problems that we have all identified.

DR. GORDON: I would like to come back to leaving that last part of the suggestion aside, come back to where we are with this Introduction.

Is there agreement that what we are looking for is simply the Commission's charge and a brief description of the meetings that we have had, which is part of what is in here, and do we want the guiding principles in here? Where are we with that? David.

DR. BRESLER: Again, with the addition as to what the concerns are that led to the Commission being formed.

DR. GORDON: But stated in a positive way without resurfacing old battles. Okay? Tom.

MR. CHAPPELL: My recommendation would be that we drop the word "Introduction," we rephrase that as the Commission's Charge, that we do not reference the history

of how we got to have the charge, and that we employ the Guiding Principles in that same section, because it says basically, in doing that, you would have here is the charge and here is the orientation that the Commission adopted to go about that charge, i.e., guiding principles.

DR. GORDON: And in the background --

MR. CHAPPELL: The history. The history would be in the History Section.

DR. BRESLER: I don't agree at all. I think nobody is going to read this report.

DR. GORDON: I think that we are clear about the tone, we are clear for the need of the Commission's charge, and the guiding principles. There is a disagreement that David and Tom are voicing between whether or not to include some background as to why the Commission got the charge.

DR. BRESLER: Not a history, but what the issues are of concern to the American people that led to the Commission being formed. That is all the background has to say, why there was a need to form this commission, and it was a damn good thing that they did, because there

are major concerns that need to be addressed. I think that that needs to be stated.

DR. GORDON: Tom, are you comfortable with that or not comfortable with that?

MR. CHAPPELL: Well, I believe that the concerns and issues that led to the formation of the Executive Order need to come to light early on in the document. There is the financial component.

DR. GORDON: Let me propose another possibility. I can discuss those issues in a vision statement which would be in front of this.

MR. CHAPPELL: Fine.

DR. GORDON: That might be one way to deal with it, and not have it in this section. Have this basically be the Commission's charge, and in the vision statement, talk about the issues that we all know well, the economic issues, issues of chronic illness, public health issues, and have that as part of the vision, and begin with that.

MR. CHAPPELL: Fine.

MR. SWYERS: Jim, can I weigh in on this for a second? Unless we go back to those legislative hearings for the Executive Order, I don't know that we can

actually say what caused Congress to form the Commission. I wouldn't feel comfortable writing that without some sort of documentation.

DR. GORDON: Okay. This is your section here, so that feels perfectly comfortable for me to discuss generally, since I was there in those discussions, in the vision statement.

MR. SWYERS: Certainly. I don't have that institutional memory. I could guess, but I think it would cause more problems than it would solve.

DR. GORDON: Joe, go ahead.

DR. FINS: I want to go back to what we want to do. Do we want to have a rhetorical victory, whatever side you are on, or do you want to pragmatically influence the public health?

I would be very uncomfortable with somebody trying to suggest why we got here, how we were legislatively constituted. I think it is simply enough to say that in response to a public health need, you know, consumer desires, concerns about safety and efficacy, the White House Commission was established, the Executive Order said this, that, and the other thing, and

then we get to the History Section, which is open to interpretation. History, as you know, is a subjective take on things, it can happen later.

History maybe should come second because it is background, it is early in the report, but I don't think we want to start off with this sort of editorializing, and I am also uncomfortable with the vision statement being so far up front, because it is sort of like where we got, it's our distillation, and without justification, it looks very sort of on shaky ground, not that it is wrong, but it may not belong there.

I think the Introduction should be very crisp, to the point, and not alienate half the readership in the process.

DR. GORDON: Joe, when I was speaking of including in the vision statement, I was going to include exactly those several points you made. This is not a huge disquisition.

The question that I would like to solve very quickly, so we can move on, because we are really at the very beginning, is do we want that paragraph or so of explanation that Joe summarized perfectly well, do we

want that here in this chapter that talks about the Commission's charge, or do we want to leave that -- there has got to be a little bit of background, and I think that you have described the little bit of background that is necessary in order to justify the existence of the Commission.

Tierona.

DR. LOW DOG: Well, I think if it was a paragraph, and very brief, that just a very brief summary and then writing to the executive charge, and then the guiding principles, and to keep it very narrow with the Commission's charge.

DR. GORDON: Fine. Linnea.

MS. LARSON: I think in this case, really, brevity is the soul of wit, and that to be very, very clear, and not go all over the map on that for what Joe Fins was saying, this is the reason, because then we get into the area of something that Jim Swyers brought in, it is legislative intent, and we do not know.

DR. GORDON: Fine. So are we agreed, Tom, is that okay, that we have a brief introductory paragraph, we have the Commission's charge, description of the

meetings, guiding principles? That is this chapter. Okay? We are on. We have got agreement on that.

DR. JONAS: Linnea, I think it was "Brevity is the soul of wisdom." But wit, too, I like that.

DR. GORDON: I just want to add that I would like to work with Jim Swyers to take the liberty of rearranging the discussion of the meetings, so I think it is important to emphasize the full commission meetings first, the town hall second, because the full commission meetings were directed by us, and there were more of them, so that is just rearranging a couple of paragraphs.

DR. FINS: Ultimately, I mean I think everybody's agreement on this is predicated upon a reading of the text and receipt of the text, so any agreement that I think any of the commissioners give right now has to be sort of conditional.

DR. GORDON: Let me say that the agreement -- thank you for saying that -- the agreement here is on the guiding principles, if you will, of rewriting the text, and that that text will then be sent out to everyone, text of all of this, within the week for your thoughts, critique, but if we are clear what is guiding us in the

writing of this, then, we should be okay.

We are not at a point where we are saying, well, that shouldn't be in here or this should be in here. We are in basic agreement with what should be in here, and the text will then go to everybody for final approval. All right? Okay.

I think that we might want to take a break. Let's take a break and then we will come back and we will talk about the History Section, and then we will move through the sections as we go along.

Let's come back in 15 minutes, give everybody enough chance to do what they have to do, come back.

[Break.]

DR. GORDON: Let's begin with CAM in the United States, Definition, Recent History, Current Status, and Prospects for the Future. Again, with Ken's help, we will put some of the issues up.

Michele Chang is on the speaker phone with us, so if you want to say hi, say hi.

MS. CHANG: Hello to everybody.

DR. GORDON: Tom.

MR. CHAPPELL: With regard to this section, I

have been part of the process here, and I guess I was making some assumptions that certain topics would be covered, that I don't see covered in the history, that I think really are a part of the formation of the whole CAM movement.

Those pieces that are missing for me are, first, an awareness of the vitamin and dietary supplement business in the forties, fifties, and sixties, which was one expression and response by manufacturers to consumer needs.

The second really was the development of the whole foods business in the sixties, seventies, and eighties, with the East-West Foundation, Air One, Paul Hawkins, Frank Ford, and so forth, that whole industry of natural foods as opposed to natural vitamins that grew up, and that was a parallel track to the vitamin industry.

But that whole foods led to holistic medicine, then, to organic foods, and then CAM is all in and around there.

DR. GORDON: Thank you, Tom.

Let me just fill everyone in and remind

everybody that we are making comments on issues that either need to be included, addressed differently, or perhaps not addressed in each section. For each section, the staff person who is responsible will be sitting, as Jim Swyers is sitting there, working with us on developing the section.

So there is going to be a back and forth, they are hearing everything we are saying. We are going to put it up on the board. Ken is putting up on the board the issues, and then we will be discussing them one by one.

So other issues for this section? Again, feel free, not only for topics, but also issues related to tone that you think we need to address.

Joe.

DR. PIZZORNO: Is it in this section that we mention the political challenges that CAM has faced over the last century, and that currently face? Where does that go?

DR. GORDON: Potentially, that can go in this section and/or in sections related to specific topics, such as licensure, such as access, et cetera.

So what are your thoughts about that, Joe?

DR. PIZZORNO: I think we just need to have one paragraph in the History Section that talks about the political challenges that have faced CAM in the last century. I don't think we need to get into a high degree of conflict or browbeating, because I think it's a mutual issue, but we can't pretend it's not there.

DR. GORDON: David, and then I think Linnea had her hand up, as well.

DR. BRESLER: Just as Tom rightfully points out, the role of the whole foods industry, I think some mention should be made of the interest in Oriental medicine that occurred with James Restin's reports and the reports of surgery under acupuncture anesthesia, which really got a lot of attention and opened up kind of like Sputnik did, you know, a lot of interest in Oriental medicine.

I think also in your Table I, there is no mention whatsoever of any of the mind-body medicine modalities. I also notice you were going to write up something about mind-body medicine. When will we see that, Jim?

DR. GORDON: I didn't know I was going to write it up until I saw the document. I have written the paragraph on it. Mind-body medicine, this table is not correct the way it is done. Mind-body medicine is a separate category. Here it says, "Herbal therapies and mind-body methods." In the revised version, it is "Mind-body methods." Do we have that revised version to hand out to everybody, Jim?

MR. SWYERS: I did send it to you. No, I don't. I can get it for you by tomorrow.

DR. GORDON: So we will hand that out, but, David, that is accounted for, both of those.

Joe.

DR. FINS: Just as a point of clarification, are we going through the whole section, or are just doing the History Section of this part? This whole thing is called History. There is a Current Status Section, which is later.

DR. GORDON: We can do the whole section, Joe. I think in this instance, it is important because it is a whole section, so a later part of the section may reflect on the earlier parts, as well.

DR. FINS: I am just going to go through it, if I could, a little bit.

Part of what I am concerned about is we need to talk about what CAM is and the definitions of that, but we also need to I think do a better effort of saying that there are certain commonalities with the conventional approach.

I think a comprehensive approach to disease treatment and health promotion that involves multiple interventions in the entire system, I am not sure what an "entire system" is. There is a kind of vagueness.

But I also think that, in spirit, that is not different than what a good primary care internist does, you know, who tells people to exercise, lose weight, stop smoking, they may use Lipitor to lower their cholesterol, but that is not incompatible.

I think if we could talk about this -- this is on page 3 and 4 of the common characteristics -- so I think the challenge here, Jim, editorially, is to talk about what is unique to CAM, but then to show that it is not necessarily and fundamentally, antithetical to what good medical care, conventional medical care is about.

I have more, if I could.

On page 5, we had talked about this, and I had referenced Paul Edelson's paper about the rise of Oslerian medicine, which I think should be cited here, but basically, Osler gained prominence as a physician because there was a heterogeneity of treatments, but there was no diagnostic clarity about what was wrong.

You even have written about this to some extent, Jim, in your paper. I think that we should talk about that and say, you know, there were a mix of different kinds of practitioners, and the last 50 or 60 years was really a period of Oslerian -- well, actually from 1892 when his textbook was written -- was a period of diagnostic evolution.

Now we have more diagnostic clarity, and there is more pluralism in therapeutic approaches instead of saying it was either/or. On pages 13 to 15 or so, it looks like scientific medicine took over somehow, and it should be said because of the success of scientific medicine.

I mean we are lucky to have life-saving hormones, sulfa drugs, and antibiotics. I should say

sulfa drugs or antibiotics. And it took over because of the success. Later on, on page 6, we also need to say that we have chronic illness because of the success of public health interventions and curative interventions that made us live longer. Now we live longer, and we are stricken with osteoarthritis.

DR. GORDON: Which page, Joe?

DR. FINS: Page 6. You don't like that? There are some conditions that I think life expectancy at the turn of the century was like in the 40's, and now it is approaching 80.

DR. WARREN: But that is not just because we have got drug therapy that helps us supposedly live longer. It doesn't mean that that is the cause of our chronic degenerative diseases.

DR. FINS: I said there were two things. There is public health interventions, as well as the medical interventions.

DR. GORDON: What I would like to do is get all the issues up there and let's talk through them one by one, but let's get them all out on the table for this chapter.

DR. FINS: I have got a few more things here. I could stop here and then I can come back if you would prefer to interrupt this, Jim, whatever you want to do.

MR. CHAPPELL: I just want to be careful not to create a justification for Western medicine in this report.

DR. GORDON: What I would like to do is to go through and get all the issues on the table, and then we can come back and discuss responses like that and like Don's response.

Let's let Joe finish. Joe is going to go through his whole list. Let him finish his whole list and then others can go through their lists of issues, as well.

DR. FINS: The point I wanted to make was that we have chronic conditions for lots of reasons, but one is that we are living longer, and why we are living longer is multifactorial, and we need to just be clear about that.

Now, on page 7, this is where I think that there is a kind of sort of, you know, it is one example doesn't make the argument problem.

People have their hands up, and I feel like I have been talking too long. I will defer to Linnea or whoever.

DR. GORDON: Effie.

DR. CHOW: This will be gone over for like wording and spelling, and things like that, will it? I am just saying the health care industry has floundered in recent decades, and then the following sentence on page 6, clinicians, health care, or found that clinicians -- so things like that are kind of interspersed through the chapter.

DR. GORDON: I think for those kinds of wordings, it would be probably easier if you want to write it out and hand it in, if it is that kind of line editing.

MR. SWYERS: Jim, I just want to add it is not cost effective for us to proofread until we have kind of a final document.

DR. CHOW: Okay, fine. One thing is that in here, Qigong is spelled with two words, and I want to make this comment for all Qigong in the whole document. Some are spelled Q-u-i-g-o-n-g. That definitely is not a

spelling of Qigong.

DR. GORDON: How do you spell it, Effie?

DR. CHOW: One word, Q-i-g-o-n-g, not two words. This has been the new spelling in China for the past 15 years.

DR. GORDON: Okay. Fair enough.

DR. CHOW: So take it for the whole document.

DR. GORDON: Other comments? Linnea.

MS. LARSON: This is addressing both Tom Chappell's interest, I believe, and Joseph Fins. I don't believe that including information about multifactorial process or multifactorial streams of what constitutes medicine in any way emphasizes Western medicine or Eastern medicine.

I think that saying that basic public health really had a major point in lengthening life, that is simple fact. I would also like to go through and make some comments about one of the criteria that I used in looking at this document, what I called "CAM rhetoric," and that is not meant in any way as an insult.

So maybe to help articulate what I mean, I will give you some examples here. One of them that could be

construed as that is the statement beginning on page 7, "Partly because conventional medicine has been slow in developing adequate treatments for many chronic conditions," for me that I really do not know, you know. I mean we are making a judgment call here that we are unclear about, and then pointing it just in the direction of complementary and alternative medicine.

Bear with me a little bit further on this, and I am going to look specifically at CAM and Cancer. It is page 8. It has to do with the uses of the research that we are using here. "A survey that assessed both the prevalence and predictors of CAM use in comprehensive cancer centers found that almost all of the patients, 99 percent, had heard of CAM. Of these patients, 83 percent has used at least one CAM approach."

Now, this is the specific thing that has to do with it. "Spiritual practices were used by the largest percentage of patients." I have, not a problem with this report, I mean this report, but I think it misses the point.

Probably many of those patients who used spiritual forms would not consider themselves to be